MidCentral District Health Board

Te Pae Hauora o Ruahine o Tararua

Part One Board Pack

17 August 2021

Printed from Stellar by
Margaret Bell <margaret.bell@midcentraldhb.govt.nz>

Contents

Agenda and karakia

17 August 2021

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MidCentral District Health Board

Board Meeting

Venue: Board Room, Gate 2 Heretaunga Street, Palmerston North

When: Tuesday 17 August 2021, from 9.00am

PART ONE

Members

Brendan Duffy (Board Chair), Heather Browning, Vaughan Dennison, Lew Findlay, Norman Gray, Muriel Hancock, Materoa Mar, Karen Naylor, Oriana Paewai, John Waldon, Jenny Warren.

Apologies

In attendance

Kathryn Cook, Chief Executive; Kelvin Billinghurst, Chief Medical Officer; Celina Eves, Executive Director, Nursing and Midwifery; Chiquita Hansen, Interim General Manager, Strategy, Planning and Performance; Gabrielle Scott, Executive Director, Allied Health; Tracee Te Huia, General Manager, Māori Health; Margaret Bell, Board Secretary.

In attendance (part meeting)

Item 4.2	Kelly Isles, Director of Strategy
Items 4.3, 4.4	Neil Wanden, General Manager, Finance and Corporate Services; Darryl Ratana, Deputy Chief Financial Officer
Item 4.5	Judith Catherwood, General Manager, Quality and Innovation
Item 4.6	Steve Miller, Chief Digital Officer; Clive Martis, Director Digital Services
Item 4.7	Keyur Anjaria, General Manager, People and Culture
Item 5.1	Simon Allan, Chair, Clinical Council
Item 5.2	Gail Munro, Chair, Consumer Council

Please contact the Board Secretary if you require a print copy – email boardsupport@midcentraldhb.govt.nz before noon on the working day prior to the meeting

1. KARAKIA 9.00

He Karakia Timata

Kia hora te marino	May peace be widespread
Kia whakapapa pounamu te moana	May the sea be smooth like greenstone
He huarahi ma tātou I te rangi nei	A pathway for us all this day
Aroha atu, aroha mai	Give love, receive love
Tātou I a tātou I ngā wa katoa	Let us show respect for each other
Hui e taiki e	

2. ADMINISTRATIVE MATTERS 9.05

2.1. Apologies

2.2. Late items

2.3. Register of Interests Update

2.4. Minutes of Board meeting held on 6 July 2021, Part One

2.5. Matters arising

2.6. Verbal report from Board Chair

2.7. HDAC – Verbal report from Committee Chair and Minutes of HDAC meeting held on 13 July 2021, Part One *(including recommendation from the HDAC meeting for the Board to consider)*

2.8. FRAC – Verbal report from Committee Chair and Minutes of FRAC meeting held on 27 July 2021, Part One

2.9. Manawhenua Hauora Chair's Report

3. DEPUTATION 9.15

New Zealand College of Midwives – Manawatu Sub-region representatives

4. PERFORMANCE REPORTING 9.30

4.1. Chief Executive's Report

4.2. Board KPI Dashboard

4.3. Finance Report – June 2021

4.4. Finance Report – May 2021

4.5. Sustainability Plan

4.6. Te Awa Update – Digital Services Work Programme

4.7. Health, Safety and Wellbeing

REFRESHMENT BREAK 10.00

5. DISCUSSION/DECISION PAPERS 10.15

5.1. Clinical Council – six-monthly report

5.2. Consumer Council – six-monthly report

5.3. Care Capacity Demand Management – six-monthly report

5.4. Meeting Dates – 2022

6. INFORMATION PAPERS 10.40

Information papers for the Board to note

6.1. Board Work Programme

7. GLOSSARY OF TERMS

8. LATE ITEMS

9. DATE OF NEXT MEETING – Tuesday 28 September 2021

10. EXCLUSION OF THE PUBLIC

Recommendation

That the public be **excluded** from this meeting in accordance with the Official Information Act 1992, section 9 for the following items for the reasons stated.

Item	Reason	Reference
'In committee' minutes of the previous Board meeting	For reasons set out in the agenda of 6 July 2021	
Combined Medical Staff and Executive Action Plan	To maintain the effective conduct of public affairs through free and frank expression of opinions	9(2)(g)(i)
Acute Mental Health Unit	To protect negotiations, including commercial and industrial	9(2)(j)
Horowhenua Respite Facility	To protect negotiations, including commercial and industrial	9(2)(j)
Midwifery Workforce Update	To maintain the effective conduct of public affairs through free and frank expression of opinions	9(2)(g)(i)
Nursing Workforce Update	To maintain the effective conduct of public affairs through free and frank expression of opinions	9(2)(g)(i)
Purchase of Anaesthetic Machines, Anaesthetic Patient Monitors and PACU Patient Monitors	To protect negotiations, including commercial and industrial	9(2)(j)
Draft Capital Expenditure Plan	To maintain the effective conduct of public affairs through free and frank expression of opinions	9(2)(g)(i)
Final Draft Budget and Annual Plan 2021/22 (after FRAC?)	To maintain the effective conduct of public affairs through free and frank expression of opinions	9(2)(g)(i)
Health Sector Reforms – Transition Plan for MidCentral District Health Board	To maintain the effective conduct of public affairs through free and frank expression of opinions	9(2)(g)(i)
Coronial Cases in 2021	To protect personal privacy	9(2)(a)
Mediation update	To maintain legal professional privilege	9(2)(h)
Chief Executive's Performance Review	To protect personal privacy	9(2)(a)
Minutes of Remuneration Committee meeting – 3 August 2021	To protect personal privacy	9(2)(a)
Board only time	No decision sought	9(2)(g)(i)
'In committee' minutes of the previous Health and Disability Advisory Committee meeting	**For reasons set out in the agenda of the 13 July 2021 meeting held with the public present**	
Serious Adverse Events (SAC 1) Report	To protect patient privacy	9(2)(a)
Consumer Story – Workshop	To protect patient privacy	9(2)(a)
'In committee' minutes of the previous Finance, Risk and Audit Committee meeting	**For reasons set out in the agenda of the FRAC meeting held on 27 July 2021**	

Administrative matters

17 August 2021

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Apologies

Any apologies to be noted?

Late items

Opportunity to advise any late items to be discussed at the meeting

Register of Interests: Summary, 14 July 2021 (Full Register of Interests available on Stellar Platform/Board/Board Reference Documents)		
Board Members		
Name	**Date**	**Nature of Interest / Company/Organisation**
Browning, Heather	4.11.19	Director – HB Partners Limited
		Member – MidCentral Governance Group Mana Whaikaha
		Board Member and Chair, HR Committee – Workbridge
	26.7.20	Director and Shareholder – Mana Whaikaha Ltd
	23.10.20	Member – Te Aho o Te Kahu (Cancer Control Agency) Consumer Reference Group
	9.2.21	Project Manager to lead Mana Whaikaha out of the Ministry of Health; stood down from appointed role of Deputy Chair of the MidCentral Governance Group for the MidCentral prototype
		Resigned as Director of Mana Whaikaha Ltd – effective from December 2020
	12.7.21	Appointed to the Support and Consultation for End of Life Choice in New Zealand (SCENZ) Group – a statutory part-time role within the Ministry of Health.
Duffy, Brendan	3.8.17	Chair and Commissioner – Local Government Commission
		Member – Representation Commission
		Chairperson – Business Kapiti Horowhenua Inc (BKH)
Dennison, Vaughan	4.2.20	Councillor – Palmerston North City Council
	9.2.21	Member of Palmerston North City Council Infrastructure Committee
Findlay, Lew	1.11.19	President, Manawatu Branch and Director Central District - Grey Power
		Councillor – Palmerston North City Council
		Member – Abbeyfield
	16.2.21	Vice President Manawatū Branch and Board Member of Grey Power New Zealand
Gray, Norman	10.12.19	Employee – Wairarapa DHB
		Branch Representative – Association of Salaried Medical Specialists
Hancock, Muriel	4.11.19	Sister is casual employee (Registered Nurse, ICU) – MidCentral DHB
		Volunteer, MidCentral DHB Medical Museum
	30.9.20	Sister-in-law is employed as a registered nurse at Whakapai Hauora
Mar, Materoa	16.12.19	Upoko Whakarae Te Tihi O Ruahine Whānau Ora Alliance
		Chair – EMERGE Aotearoa
		Matanga Mauri Ora Ministry of Health Mental Health and Addiction
		Chair, 'A Better Start – E Tipu Rea', National Science Challenge, Liggins Institute, University of Auckland
	11.2.20	Member of MDHB Cluster
		Member of local Child and Youth Mortality Review Group (CYMRG)
	5.8.20	Member of MDHB's Māori Alliance Leadership Team (MALT)
	13.7.21	Member – Te Ahu Whenua Māori Land Trust

Register of Interests: Summary, 14 July 2021 (Full Register of Interests available on Stellar Platform/Board/Board Reference Documents)		
Naylor, Karen	6.12.10 9.10.16	Employee – MidCentral DHB Member and Workplace Delegate – NZ Nurses Organisation Councillor – Palmerston North City Council
Paewai, Oriana	1.5.10 13.6.17 30.8.18 13.4.21 27.7.21	Member – Te Runanga o Raukawa Governance Group Chair – Manawhenua Hauora Co-ordinating Chair – Te Whiti ki te Uru (Central Region DHB MRBs) Member Nga Manu Taiko, a standing committee of the Council – Manawatu District Council Member – Te Tihi o Ruahine Whānau Ora Alliance Board Member – Cancer Society Manawatu Appointed Member – Massey University Council Trustee – Manawatū/Whanganui Children's Health Charitable Trust Board Member – Governance Board, Mana Whaikaha
Waldon, John	22.11.18 9.2.21	Co-director and co-owner – Churchyard Physiotherapy Ltd Co-director and researcher – 2 Tama Limited Manawatu District President – Cancer Society Executive Committee Central Districts (rep for Manawatu, 1 of 2) – Cancer Society Has a contract with UCOL
Warren, Jenny	6.11.19 12.2.21 1.7.21	Team Leader Bumps to Babies – Barnardos New Zealand Consumer Representatives National Executive Committee – National On Track Network Pregnancy and Parenting Education Contractor – Palmerston North Parents' Centre Member of Locality Advisory Group for both Tararua and Ōtaki/Horowhenua for the Primary Maternity Project Enhancing NZ Clinical Trials – member of Consumer Focus Group (run by the Liggins Institute with funding from the Ministry of Health and Health Research Council)
Committee Members		
Allan, Simon (FRAC)	2.6.20	Deputy Chair – Manawatu Branch of Cancer Society MDHB Rep – THINK Hauora Palliative Care Advisory Panel (Ministry of Health advisory body) Director of Palliative Care – Arohanui Hospice Chair of Board – Manawatu Badminton Association

Register of Interests: Summary, 14 July 2021 (Full Register of Interests available on Stellar Platform/Board/Board Reference Documents)		
Hartevelt, Tony (FRAC)	14.8.16 14.8.16 14.8.16 7.10.19	Independent Director – Otaki Family Medicine Ltd Elder son is Director, Global Oncology Policy based at Head Office, USA – Merck Sharpe & Dohme (Merck) (NZ operations for Global Pharmaceutical Company) Younger son is news director for Stuff.co.nz – Fairfax Media Independent Chair, PSAAP's Primary Care Caucus – Primary Health Organisational Service Agreement Amendment Protocol (PSAAP)
Munro, Gail (HDAC)	23.3.21	Director – Eastern and Central Trust 2020 Governance Strategies Ltd 2007
Management		
Cook, Kathryn	13.4.21	Nil
Ambridge, Scott	20.8.10	Nil
Amoore, Anne	23.8.04	Nil
Anjaria, Keyur	17.7.17	Wife is a user of the Needs Assessment and Service Co-ordination Service – MDHB
Bell, Margaret	28.7.20	Nil
Billinghurst, Kelvin	6.8.20	Fellow of the Royal College of Medical Administration (RACMA) Coordinator for the Indigenous Health Programme – RACMA Member of the Rural Policy Advisory Group – RACMA Fellow of the Australasian College of Health Service Managers (ACHSM)
Bradnock, Barb	26.8.10	Nil
Brogden, Greg	16.2.16	Nil
Brown, Jeff		TBA
Caldwell, Vanessa	7.5.18	Nil
Catherwood, Judith	1.5.18	Nil
Davies, Deborah	18.5.18	Member, Alliance Leadership Team – Central PHO Daughter is an employee and works within hospital services – MidCentral DHB
Eves, Celina	14.5.18 20.4.20	Owner personal consulting company, UK – Celina Eves Limited (2020 moved into dormancy) Trustee – Palmerston North Medical Trust
Fenwick, Sarah	13.8.18	Nil
Free, Jennifer	6.8.20	Nil
Hansen, Chiquita	9.2.16 3.3.21	Employed by MDHB and seconded to Central PHO 8/10ths – MidCentral DHB CEO – Central PHO Employed by THINK Hauora as Chief Executive and seconded to MidCentral DHB as Interim General Manager, Strategy, Planning and Performance 6/10ths Husband is employed by MidCentral DHB Executive member of General Practice New Zealand (GPNZ)

Register of Interests: Summary, 14 July 2021 (Full Register of Interests available on Stellar Platform/Board/Board Reference Documents)		
		Executive member of Health Care Home Collaborative
Hardie, Claire	13.8.18 13.8.18 13.8.18	Member – Royal Australian & NZ College of Radiologists Trustee – Palmerston North Hospital Regional Cancer Treatment Trust Inc Member, Medical Advisory Committee – NZ Breast Cancer Foundation
Horgan, Lyn	1.5.17 18.5.18	Sister is Coroner based in Wellington – Coronial Services Member, Alliance Leadership Team – Central PHO
Howe, Jonathon	1.8.19	Nil
Matthews, Rory	20.8.20	Managing Partner, FGI (NZ) Ltd trading as Francis Health Trustee/Director Te Hopai Home and Hospital Ltd
Miller, Steve	18.4.17 26.2.19 6.3.19 1.10.19	Director. Farming business – Puriri Trust and Puriri Farm Partnerships Board Member, Member, Conporto Health Board Patient's First trading arm – Patients First Member, Alliance Leadership Team, Member, Information Governance Group – Central PHO Chair – National DHB Digital Investment Board
Ratana, Darryl	29.5.19	Nil
Russell, Greig	3.10.16	Minority shareholder – City Doctors Member, Education Committee – NZ Medical Council
Scott, Gabrielle	Dec 19	Son is a permanent MDHB employee and works within Digital Services
Tanner, Steve	16.2.16	Nil
Te Huia, Tracee	13.7.21	Member of the No Ngā Hau e whā branch of the Māori Women's Welfare League
Wanden, Neil	Feb 19	Nil
Williamson, Nicki	Mar 20	Nil
Zaman, Syed	1.5.18	Nil

Resolution

That the Part One minutes of the 6 July 2021 Board meeting be approved as a true and correct record.

MidCentral District Health Board

Board Minutes

Meeting held on 6 July 2021 from 9.00am

PART ONE

Members

Brendan Duffy (Board Chair), Heather Browning, Vaughan Dennison, Lew Findlay, Norman Gray, Muriel Hancock, Materoa Mar, Karen Naylor, Oriana Paewai, John Waldon, Jenny Warren.

In attendance

Kathryn Cook, Chief Executive; Kelvin Billinghurst, Chief Medical Officer; Celina Eves, Executive Director, Nursing and Midwifery; Chiquita Hansen, Interim General Manager, Strategy, Planning and Performance; Rory Matthews, Interim Director, Office of the Chief Executive; Gabrielle Scott, Executive Director, Allied Health; Tracee Te Huia, General Manager, Māori Health; Margaret Bell, Board Secretary.

In attendance (part meeting)

Keyur Anjaria, General Manager, People and Culture; Wayne Blissett, Operations Executive, Pae Ora Paiaka Whaiora; Judith Catherwood, General Manager, Quality and Innovation; Kelly Isles, Director of Strategy; Sam Kilmister, Communications and Social Media Advisor; Jessica Long, Advisor, Planning and Accountability; Steve Miller, Chief Digital Officer; Darryl Ratana, Deputy Chief Financial Officer; Connie Roos, Organisational Development Business Partner; Barbara Ruby, Advisor, Strategy and Planning; Neil Wanden, General Manager, Finance and Corporate Services.

Media – 0

Public – 0

1. KARAKIA

The meeting opened with the organisational karakia.

2. ADMINISTRATIVE MATTERS

2.1. Apologies

Nil.

2.2. Late items

There were no late items.

2.3. Register of Interests Update

Jenny Warren

Add: Member of Clinical Focus Group for Enhancing NZ Clinical Trials – run by the Liggins Institute with funding from the Ministry of Health and the Health Research Council.

2.4. Minutes of the 25 May 2021 meeting, Part One

It was resolved that:

> *the Part One minutes of the 25 May 2021 Board meeting be approved as a true and correct record.*
>
> *(Moved Vaughan Dennison; seconded John Waldon)*

2.5. Minutes of the 15 June 2021 Board and Finance, Risk and Audit Committee conjoint meeting, Part One

It was resolved that:

> *The Part One minutes of the 15 June 2021 Board and Finance, Risk and Audit Committee conjoint meeting be approved as a true and correct record.*
>
> *(Moved Oriana Paewai; seconded Heather Browning)*

2.6. Matters arising from previous minutes

The General Manager, Quality and Innovation provided a verbal update on an issue raised at a walk-round in March 2020. Wheelchair access was available at the front entrance of the building used for the Alcohol and Other Drug services. Wheelchair access to the rear of the building was being addressed.

2.7. Verbal report from the Board Chair

The magnitude of change arising from the review of the health system was significant. While Board members and staff were aware of the opportunities, challenges and threats, there was very little understanding of the changes in the wider community. Over the next 12 months, the Board would need to be brave in its decision making; would need to be empathetic to the vision of health delivery; and would need to nurture, guide, harness and reflect. It is a privilege and a responsibility to implement the Government's changes. The physical location of MidCentral District Health Board (MDHB) provided an opportunity to be a centre for the region for the delivery of medical services and administration.

2.8. Minutes of the Finance, Risk and Audit Committee meeting held on 15 June 2021, Part One

In response to a question, management advised that a report on options for Enable New Zealand in the health reforms would be presented to the September Finance, Risk and Audit Committee (FRAC) meeting before being presented to the Board for consideration.

It was resolved to:

note the unconfirmed Part One minutes of the Finance, Risk and Audit Committee (FRAC) meeting held on 15 June 2021.

(Moved Oriana Paewai; seconded Vaughan Dennison)

2.9. Manawhenua Hauora Chair's Report

The report was taken as read. The Board acknowledged Materoa Mar's nomination by Manawhenua Hauora for the Māori Health Authority.

It was resolved to:

note the report from the Manawhenua Hauora Chair on the Manawhenua Hauora meeting held in May 2021

note the General Manager, Māori Health's response to the Chair's report.

(Moved Oriana Paewai; seconded Muriel Hancock)

3. STRATEGIC FOCUS

Discussion to be held in Part Two of the meeting.

4. PERFORMANCE REPORTING

4.1. Chief Executive's Report

The Chief Executive presented this report, which was taken as read. The following responses were provided by management to questions raised.

- There were no practical implications related to the International Accreditation New Zealand (IANZ) suspension of the Medical Imaging Department's accreditation. Not all District Health Boards (DHBs) seek IANZ accreditation and can still provide services. IANZ do not recognise the specialists who read MDHB reports, as they are part of a contracted workforce.
- The Ministry of Health's (the Ministry) guidance on the implementation of the End of Life Choice Act 2019 is being refreshed. The Clinical Executive, Te Uru Mātai Matengau is MDHB's lead and will provide a report to the September meeting of the Health and Disability Advisory Committee (HDAC).
- There was high patient demand during the nurses strike on 9 June 2021. An agreement with the NZ Nurses Organisation (NZNO) was in place to provide Life Preserving Services. Some nurses stayed on to work and volunteers helped to provide care to patients.

A Board member noted that MDHB was doing better than many other DHBs in providing COVID-19 vaccinations for iwi Māori. She acknowledged the work done by the Tumu Rautaki, Pae Ora Paiaka Whaiora.

It was resolved that the Board:

note the update of key local, regional and national matters.

(Moved Vaughan Dennison; seconded Muriel Hancock)

The Interim Director of the Office of the Chief Executive and the Advisor, Strategy and Planning joined the meeting.

4.2. Board KPI Dashboard

The Director of Strategy presented this report, which was taken as read. It was noted the dashboard showed trends and whether MDHB was achieving targets.

Childhood immunisation rates were being closely monitored and an improvement plan was being led by THINK Hauora.

It was resolved that the Board:

note the areas highlighted in the KPI dashboard and associated commentary.

(Moved Jenny Warren; seconded John Waldon)

4.3. Finance Update – May 2021

The General Manager, Finance and Corporate Services and the Deputy Chief Financial Officer presented this report, which was taken as read.

The Chief Executive advised that KPMG had been appointed by the Ministry to provide independent strategic project management via a centralised function for all 20 DHBs on the Holidays Act remediation project. They would conduct an audit of each DHB's calculations before the Government released any funding.

It was resolved that the Board:

note that the month operating result for May 2021 is a surplus before one-off items of $0.219m, which is $0.735m favourable to budget

note that the year to date result for May 2021 is a surplus before one-off items of $0.399m, which is $3.857m favourable to budget

note that year to date to May 2021 COVID-19 related net costs of $0.100m and unbudgeted Holidays Act related costs of $2.978m have been incurred. Including these one-off costs results in a year to date deficit after exceptional items of $2.680m, which is $0.779m favourable to budget

note that total available cash and equivalents of $45.9m as at 31 May 2021 is sufficient to support liquidity requirements

note that this is an interim finance report and that a full report will come to the Board for consideration at its August meeting.

(Moved Vaughan Dennison; seconded Norman Gray)

4.4. Finance Report – April 2021

The General Manager, Finance and Corporate Services and the Deputy Chief Financial Officer presented this report, which was taken as read.

It was resolved that the Board:

note that this paper was endorsed by the Finance, Risk and Audit Committee at their 15 June 2021 meeting

note that the month operating result for April 2021 is a deficit before one-off items of $0.793m, which is $0.452m favourable to budget

note that the year to date operating result to April 2021 is a surplus before one-off items of $0.179m, which is $3.122m favourable to budget

note that year to date to April 2021 COVID-19 related net costs of $0.100m and unbudgeted Holidays Act related costs of $2.616m have been incurred. Including these one-off costs results in a year to date deficit after exceptional items of $2.537m. This is favourable to budget by $0.406m

note that the total available cash and equivalents of $48.7m as at 30 April 2021 is sufficient to support liquidity requirements

approve the April 2021 financial report.

(Moved Vaughan Dennison; seconded Norman Gray)

4.5. **Sustainability Plan Report**

The General Manager, Quality and Innovation presented this report, which was taken as read.

A Board member asked how decisions would be made on which projects were paused and which proceeded. The Chief Executive noted the Board had agreed not to start projects that would be impacted by the health system reform, such as implementing a new payroll system. It was important to ensure there was capacity and capability in place to deliver the essential workload and not over-burden staff. Every DHB was facing resignations from staff, particularly in enabler areas, which increased the workload pressure on remaining staff.

The Chief Executive advised that transition planning and discussions were taking place at both a national and regional level. A transition plan for MDHB was being developed, but more information was needed about the national and regional plans to ensure consistency. A draft MDHB transition plan would be presented to the August Board meeting.

It was resolved that the Board:

note the Finance, Risk and Audit Committee endorsed this report at its June meeting for the Board's consideration

note the emerging risks and mitigation plans

note the 2020/21 benefits realisation reconciliation is in progress

approve the refreshed Sustainability Plan 2020-2023.

(Moved Muriel Hancock; seconded Materoa Mar)

The Communications and Social Media Advisor left the meeting.

The General Manager, People and Culture; the Organisation Development Business Partner; and the Operations Executive, Pae Ora Paiaka Whaiora joined the meeting.

4.6. **Te Awa Update – Digital Services Work Programme**

The Chief Digital Officer presented this report, which was taken as read. He thanked clinical staff for their efforts during a recent outage required to upgrade Clinical Portal and improve cyber security. A further review of all third-party software suppliers would be carried out.

The Board extended thanks to the Chief Digital Officer and his team for their efforts to ensure the organisation's cyber security systems were robust.

It was resolved that the Board:

> *note that due to the Government's announcement on health system reforms, no new discretionary initiatives from the Te Awa Digital Health Strategy (Te Awa) roadmap will be started, apart from core legacy technology and infrastructure priorities*
>
> *note the work programme covering planned work through into the 2021/22 financial year*
>
> *note the national and regional activity that may impact on the planned work programme.*
>
> *(Moved Oriana Paewai; seconded Vaughan Dennison)*

4.7. **Non-financial Performance Measures – Quarter Three**

The Advisor, Strategy and Planning presented this report, which was taken as read. As requested by the Board, this was now an exception report, with detailed reports available on the Stellar platform for the Board to review.

It was resolved that the Board:

> *note the summary report on Stellar and progress made in delivering MidCentral District Health Board's Annual Plan and performance expectations for the third quarter of 2020/21*
>
> *note the mitigations in place for those performance measures or deliverables that were not meeting expectations for Quarter Three.*
>
> *(Moved Vaughan Dennison; seconded Muriel Hancock)*

The Advisor, Strategy and Planning left the meeting.

5. DISCUSSION/DECISION PAPERS

5.1. Year-end Audit Process

The General Manager, Finance and Corporate Services presented this report, which was taken as read.

It was resolved that the Board:

approve that the Board Chair and a Board member be authorised to sign the Letter of Representation in respect of the 2020/21 year-end financial return to the Ministry of Health.

(Moved Muriel Hancock; seconded Materoa Mar)

5.2. Fraud, Theft and Corrupt Actions Prevention Policy

The General Manager, Finance and Corporate Services presented this report, which was taken as read.

It was resolved that the Board:

note that the Finance, Risk and Audit Committee endorsed the revised Fraud, Theft and Corrupt Actions Prevention Policy at its March 2021 meeting

note that the Fraud Prevention Policy has been reviewed and a number of adjustments are proposed to improve its effectiveness

note the name change from Fraud Prevention Policy to Fraud, Theft and Corrupt Actions Prevention Policy

approve the revised Fraud, Theft and Corrupt Actions Prevention Policy.

(Moved Oriana Paewai; seconded Karen Naylor)

5.3. Manawhenua Hauora and MDHB Shared Work Plan 2021/22

The Operations Executive, Pae Ora Paiaka Whaiora presented this report, which was taken as read. He acknowledged Matariki, the Māori New Year was a time to remember loved ones who had been lost over the last year.

A Board member noted that the shared work plan demonstrated a positive relationship between iwi and MDHB and thanked the Operations Executive for his work.

The Board Chair acknowledged the work of the Operations Executive in developing the bond between Manawhenua Hauora and MDHB. His measured and respectful manner had brought the two entities together. While it was sad the Operations Executive was about to leave MDHB, it was exciting that he would be working in the iwi sector in the community. The Board Chair extended thanks on behalf of the Board.

The Operations Executive thanked the Board and wished everyone the strength, courage and tenacity that would be required to face the challenges ahead.

It was resolved that the Board:

approve the Manawhenua Hauora and MidCentral District Health Board Shared Work Plan 2021/22 for implementation.

(Moved Karen Naylor; seconded John Waldon)

The Operations Executive, Pae Ora Paiaka Whaiora and the Chief Digital Officer left the meeting.

5.4. Psychosocial Wellbeing Strategy

The General Manager, People and Culture and the Organisational Development Business Partner presented this report, which was taken as read.

A Board member expressed her concern that the Māori models had not been used correctly.

The Chief Executive noted that although the Pae Ora Paiaka Whaiora Directorate had been involved in developing the Psychosocial Wellbeing Strategy, it had not been presented to Manawhenua Hauora for endorsement. She suggested that process should be followed before the strategy was re-presented to the Board.

It was resolved that the Board:

note that the Psychosocial Wellbeing Strategy would be presented to Manawhenua Hauora for endorsement before being presented to the Board for approval.

(Moved Materoa Mar; seconded Karen Naylor)

The General Manager, People and Culture and the Organisational Development Business Partner left the meeting.

6. INFORMATION PAPERS

6.1. NZ Health Partnerships – Quarterly Report

The General Manager, Finance and Corporate Services presented this report, which was taken as read.

It was resolved that the Board:

note the update on activities within New Zealand Health Partnerships.

(Moved Jenny Warren; seconded Muriel Hancock)

6.2. **Board's Work Programme**

This Interim Director of the Office of the Chief Executive presented this report, which was taken as read. He noted the report was to provide the Board with reassurance that management had done what had been asked.

It was resolved that the Board:

note the Board's annual work programme.

(Moved Vaughan Dennison; seconded Karen Naylor)

7. GLOSSARY OF TERMS

8. LATE ITEMS

It was agreed to send a letter of congratulations to former MDHB Board member, Barbara Cameron, who had been awarded a QSM in the 2021 Queen's Birthday Honours.

9. DATE OF NEXT MEETING

Tuesday, 17 August 2021 – Board Room, MidCentral District Health Board, Gate 2 Heretaunga Street, Palmerston North.

10. EXCLUSION OF PUBLIC

It was resolved:

that the public be excluded from this meeting in accordance with the Official Information Act 1992, section 9 for the following items for the reasons stated:

Item	Reason	Ref
'In committee' minutes of the previous Board meeting	For reasons set out in the agenda of the 25 May 2021 meeting	
'In committee' minutes of the Board and Finance, Risk and Audit Committee conjoint meeting	For reasons set out in the agenda of the 15 June 2021 meeting	
Final Draft Budget 2021/22	To maintain the effective conduct of public affairs through free and frank expression of opinions	9(2)(g)(i)

Item	Reason	Ref
Midwifery Workforce Update	To maintain the effective conduct of public affairs through free and frank expression of opinions	9(2)(g)(i)
Nursing Workforce Update	To maintain the effective conduct of public affairs through free and frank expression of opinions	9(2)(g)(i)
Establishment of an Acute Services Block and Re-lifing of the Clinical Services Block	To protect negotiations, including commercial and industrial	9(2)(j)
Print Technology and Associated Services	To protect negotiations, including commercial and industrial	9(2)(j)
Upgrade of Water Systems, Palmerston North Hospital	To protect negotiations, including commercial and industrial	9(2)(j)
Step-down facility, Mental Health and Addiction Services	To protect negotiations, including commercial and industrial	9(2)(j)
Board only time	No decision sought	
Workshop – Medical Workforce	To maintain the effective conduct of public affairs through free and frank expression of opinions	9(2)(g)(i)
'In Committee' minutes of the previous FRAC meeting	**For reasons set out in the agenda of the FRAC meeting held on 15 June 2021**	

(Moved Vaughan Dennison; seconded Oriana Paewai)

Part One of the meeting closed at 10.50am

Confirmed this 17th day of August 2021

……..

Board Chair

MidCentral District Health Board

- Schedule of Matters Arising, 2021/22 as at 17 July 2021

Matter	Raised	Scheduled	Responsibility	Form	Status
Report on options for Enable New Zealand in the health reforms – FRAC meeting then Board	July 21	Sept 21	B Duffy	Report	Scheduled
Future Quality and Safety Walk-round reports to include details of actions and any themes	May 21	May 22	J Catherwood	Report	Scheduled
Internal audit report – Māori Health Equity Review to be included on the agenda for a future MDHB and Manawhenua Hauora Board hui	April 21	Aug 21	T Te Huia	Report to Manawhenua Hauora	Scheduled
Discuss recruitment of a person with lived experience of disability to become a member of HDAC with the Consumer Council chair	Dec 20	~~Feb 21~~ May 21	B Duffy	Report	Commenced
Review of car parking arrangements PNH, including readdressing all carpark feedback and suggestions (Dec 20: after traffic engineering review completed)	April 17	Ongoing	N Wanden	Report	Scheduled
COMPLETED					
Present a draft health sector reforms transition plan for MDHB	July 21	Aug 21	V Caldwell	Report	Completed
Provide more detailed commentary about incidents in Health, Safety and Wellbeing dashboard reports, including how they are being addressed	May 21	Aug 21	K Anjaria	Report	Completed
Include details on workforce shortages in the Health, Safety and Wellbeing report if data is available	May 21	Aug 21	K Anjaria	Report	Completed
Provide breakdown by service area for incidents of staff shortages, including location, what was being recorded, why it was being recorded and what was being done to address the issue	Feb 21	~~May 21~~ Aug 21	K Anjaria	Report	Completed
Write letter of congratulations to former Board member, Barbara Cameron, on receiving QSM in Queen's Birthday Honours	July 21	July 21	B Duffy	Letter	Completed
Check on wheelchair access for Alcohol and Other Drug services – from walk-round March 2020	May 21	July 21	J Catherwood	Verbal update	Completed
Send calendar invitations for long service awards ceremonies to Board members	May 21	June 21	M Bell	Meeting invite	Completed

Verbal report from the Board Chair

The Board Chair will provide an update on recent activities

Resolution

That the Part One minutes of the 13 July 2021 Health and Disability Advisory Committee meeting be approved as a true and correct record.

Resolution for the August Board meeting

That the Board consider writing to the Ministry of Health to highlight issues faced by migrant GPs in gaining residency.

MidCentral District Health Board

Health and Disability Advisory Committee Minutes

Meeting held on 13 July 2021 from 9.00am

PART ONE

Members

John Waldon (Committee Chair), Brendan Duffy (Board Chair), Heather Browning, Vaughan Dennison, Norman Gray, Muriel Hancock, Materoa Mar (Deputy Committee Chair), Gail Munro, Karen Naylor, Oriana Paewai, Jenny Warren.

Apologies

Lew Findlay for the meeting. Oriana Paewai, Materoa Mar and Karen Naylor for departing early.

In attendance

Kathryn Cook, Chief Executive; Kelvin Billinghurst, Chief Medical Officer; Judith Catherwood, General Manager, Quality and Innovation; Celina Eves, Executive Director, Nursing and Midwifery; Chiquita Hansen, Interim General Manager, Strategy, Planning and Performance; Gabrielle Scott, Executive Director, Allied Health; Tracee Te Huia, General Manager, Māori Health; Kerry Hunt, Executive Assistant.

In attendance (part meeting)

Scott Ambridge, Operations Executive, Te Uru Rauhī; Keyur Anjaria, General Manager, People and Culture; Dr Jeff Brown, Clinical Executive, Te Uru Pā Harakeke; Dr Vanessa Caldwell, Clinical Executive, Te Uru Rauhī; Mariette Classen, Consumer Experience Manager; Sarah Fenwick, Operations Executive, Te Pā Harakeke; Claire Hardie, Clinical Executive, Te Uru Mātai Matengau; Lyn Horgan, Operations Executive, Te Uru Arotau; Kelly Isles, Director of Strategy; Angela Rainham, Locality and Intersectoral Development Manager; Michalle Riwai, General Manager, Enable New Zealand, Alison Russell, Planning and Integration Lead, Te Uru Kiriora; Dr Syed Zaman, Clinical Executive, Te Uru Whakamauora.

Media – 1; Public – 0

1. KARAKIA

The meeting opened with the organisational karakia.

2. ADMINISTRATIVE MATTERS

2.1. Apologies

An apology from Lew Findlay was received and accepted. An apology was received from Materoa Mar and Karen Naylor who departed the meeting at 11.45am and noon respectively.

2.2. Late items

A late item was received for Part Two of the agenda – Provisional Suspected Suicide Statistics MidCentral DHB.

2.3. Register of Interests Update

The following updates to the Register of Interests were advised.

Heather Browning

Add

- Member, Support and Consultation for End of Life Choice in New Zealand (SCENZ) Group.

Materoa Mar

Add

- Member, Te Ahu Whenua Māori Land Trust

2.4. Minutes of the 27 April 2021 meeting, Part One

It was resolved that:

> *the Part One minutes of the 27 April 2021 Health and Disability Advisory Committee meeting be approved as a true and correct record.*
>
> *(Moved John Waldon; seconded Materoa Mar)*

2.5. Matters arising from previous minutes

No discussion.

3. STRATEGIC FOCUS

3.1. Disability Service Strategic Direction

The Executive Director Allied Health and the General Manager, Enable New Zealand presented a Disability Sector Overview.

A review of the disability support system is due in September 2021 as the Government has requested further advice on this component of the health and disability system.

Health and Disability Advisory Committee (HDAC) members acknowledged the passing of Maxine Dale, who was pivotal in co-designing and supporting the Enabling Good Lives rollout within the MidCentral DHB region.

In response to a question it was acknowledged that there are still considerable inequities for Māori in the disability sector. It is hoped that this will be addressed by the current health reforms and the formation of the Māori Health Authority.

It was resolved that the Committee:

note the presentation on the strategic direction for disability services

endorse the direction of disability services.

(Moved Muriel Hancock; seconded Vaughan Dennison)

4. DIRECTORATE WITH CLUSTER FUNCTIONS REPORTING

4.1. Directorate Dashboard

The Operations Executive, Te Uru Arotau presented this report, which was taken as read.

It was resolved that the Committee:

note the areas highlighted in the dashboard and associated commentary.

(Moved John Waldon; seconded Karen Naylor)

4.2. Te Uru Mātai Matengau – Cancer Screening, Treatment and Support

The Operations Executive and Clinical Executive, Te Uru Mātai Matengau presented this report, which was taken as read.

It was confirmed that the risk identified with the Mosaiq move to a cloud-based solution has been mitigated by resource allocation signoff.

The Clinical Executive gave an update on the status of both Taranaki and Hawke's Bay DHB business cases for their capital investment projects.

4.3. Te Uru Pā Harakeke – Healthy Women, Children and Youth

The Operations Executive and the Clinical Executive, Te Uru Pā Harakeke presented this report, which was taken as read.

Midwifery services are recruiting a permanent Director of Midwifery and implementing the change paper with strengthened midwifery leadership positions.

Tūngia te Ururua project has not yet received sufficient input from Māori and Pasifika, in part because of their necessary focus on COVID-19 vaccination. The timeframe for the project has been extended to ensure engagement and responses are as representative of our population as possible.

In response to a question the Operations Executive confirmed that MDHB has been involved with the Police to strengthen the Family Violence Intervention Programme.

In response to a question about the surcharges for obstetric ultrasound by private providers, the Operations Executive agreed that more would be done to communicate the availability of private providers who do not surcharge for some women such as Community Service Cardholders.

4.4. Te Uru Whakamauora – Healthy Ageing and Rehabilitation

The Clinical Executive, Te Uru Whakamauora presented this report, which was taken as read. The departure of the Directorate's Operations Executive, Andrew Nwosu, was noted.

A 12-week pilot for the provision of community stroke rehabilitation services has commenced. This will allow some patients to be able to access rehabilitation services in their own homes. Results of the pilot should be available by the next HDAC meeting.

In response to a question about wait times for SupportLinks assessments, it was confirmed that the increase in wait times was due to staff vacancies. Recruitment is being actively pursued which should lead to a reduction in wait times. The Committee was reassured that pending full assessment, clients are being offered Packages of Temporary Support (PoTS) and access to respite care.

HDAC members acknowledged and congratulated the Te Uru Whakamauora team on the letter of compliment received from the Ombudsman's office on the environmental improvements on the STAR 1 unit since the Ombudsman's inspection in 2020.

4.5. Te Uru Rauhī – Mental Health and Addiction Services

The Operations Executive and Clinical Executive, Te Uru Rauhī presented this report, which was taken as read.

The Operations Executive confirmed that the paper on the Horowhenua Community step-up service was delayed due to the budgeting process. The paper will be presented to the Board in August for approval.

There was strong support for the Integrated Model of Care proposal, with 62 submissions received from staff and unions.

In response to a question about the escalation in Did not Attends (DNAs) the Operations Executive confirmed that alternative options for appointments via phone or Zoom will be considered as part of the implementation of the Integrated Model of Care as it provides clients with flexibility to be able to keep appointments. Further, under the new Integrated Model of Care the service will be able to offer after hours appointments which will increase service access.

In response to a question there was confirmation that an Acute Mental Health Unit design session will be held with the Board at their 17 August 2021 meeting. The 2021/22 budget provision for extra staff will avoid staff undertaking double shifts in Ward 21.

4.6. Te Uru Arotau – Acute and Elective Specialist Services

The Operations Executive, Te Uru Arotau presented this report, which was taken as read.

The acute patient demand is a national issue coupled with the additional respiratory illness which is prevalent in the community. The Operations Executive explained how the Transitory Care Unit is being utilised to cope with the current demands in the hospital.

The Clinical Executive, Te Uru Mātai Matengau gave an update on Telehealth Working Group. Telehealth implementation is progressing and will be introduced across other directorates.

In response to questions on the unmet need/Did Not Waits in the Emergency Department, it was confirmed that the Emergency Department data will have a more detailed focus in future HDAC reporting.

4.7. Te Uru Kiriora – Primary, Public and Community Health

The Clinical Executive and the Planning and Integration Lead, Te Uru Kiriora presented this report, which was taken as read.

In response to a question about how the public knows where they can enrol with a General Practitioner (GP) due to a shortage of GPs in the Horowhenua and Foxton areas, the Clinical Executive will take this issue back to discuss with the team. It was noted that the information is regularly updated on the THINK Hauora website. It was suggested that THINK Hauora be invited to a future meeting to have a discussion around GP availability.

In response to a question the Planning and Integration Lead, Te Uru Kiriora confirmed that the ethnicity and locality information of the COVID-19 vaccine rollout in the region could be put up on the website.

5. PERFORMANCE REPORTING

5.1. Enable New Zealand Report

The General Manager, Enable New Zealand spoke to the paper.

The volume of clients is increasing each month, and a plan to address the pressure on service has been developed.

HDAC Committee members congratulated the General Manager on the great work Enable is doing.

It was resolved that the Committee:

endorse the Enable New Zealand Report to 31 May 2021.

(Moved John Waldon; seconded Materoa Mar)

5.2. Pae Ora Paiaka Whaiora Report

The General Manager, Māori Health presented this report, which was taken as read. The General Manager said she was very proud of the other Directorates efforts toward Māori health evidenced in their reporting.

The Board and Manawhenua Hauora have now approved their shared work plan, and the team are currently developing the workplan related to the internal audit by Technical Advisory Services (TAS) on equity.

There has been high demand for Te Tiriti o Waitangi training with some Directorates funding additional training.

It was resolved that the Committee:

note the progress update for the Pae Ora Paiaka Whaiora, the Māori Health Directorate.

(Moved Vaughan Dennison; seconded Materoa Mar)

6. DISCUSSION/DECISION PAPERS

6.1. Clinical Governance and Quality Improvement Framework

The General Manager, Quality and Innovation presented this report, which was taken as read.

It was resolved that the Committee:

note the development and implementation of The Quality Agenda (Clinical Governance Framework) to date

note the development of the accompanying frameworks to support quality improvement and innovation

note the achievements in improving quality, safety, and clinical governance arrangements

endorse the proposal that future reporting on quality and safety programmes and improvement will be provided in the quarterly Quality Accounts, the Quality and Safety Dashboard and Directorate reports.

(Moved John Waldon; seconded Oriana Paewai)

6.2. Māori Health Equity Dashboard – Te Ara Angitū Report – Mental Health and Addiction Services Adult Indicators

The Operations Executive and Clinical Executive, Te Uru Rauhī presented this report, which was taken as read.

The Operations Executive will advise HDAC members of the number of responses to the online survey.

It was resolved that the Committee:

note the equity position for each of the indicators

note the analysis, discussion and proposed next steps to improve Māori health equity and further strengthen MidCentral District Health Board's commitment to Te Tiriti o Waitangi

endorse the Te Ara Angitū report, Mental Health and Addiction Services Adult Indicators.

(Moved Materoa Mar; seconded Heather Browning)

6.3. Māori Health Equity Dashboard Report – Workforce Indicators

The General Manager, People and Culture presented this report, which was taken as read. He noted that the target of Māori staff within MDHB has not been met and the appointment of the Senior Māori Workforce Development Officer should see the DHB make positive progress in this area.

There is a focus on increasing the attendance of medical staff in the cultural responsiveness and Te Tiriti o Waitangi training. Recruitment of women and Māori into senior medical roles is another area of focus. Following feedback from the Committee it was noted that the recruitment of 'women' and 'Māori' into senior medical roles should not be linked. There is a recruitment issue developing as numerous organisations wish to expand their Māori workforce.

There was discussion around pay parity and its impact on staffing across the sector. It was noted that DHBs have been asked by the Ministry of Health not to engage in discussion around pay parity as it was being handled nationally.

It was resolved that the Committee:

note the progress made on workforce indicators identified for the 2020/21 year

note the analysis, discussion and proposed next steps to improve the current workforce indicators, and strengthen MidCentral District Health Board's commitment to Te Tiriti o Waitangi

endorse the Workforce Indicators report.

(Moved Muriel Hancock; seconded Karen Naylor)

6.4. Regional Services Plan Implementation, Quarter 3 – 2020/21

The Director of Strategy, Planning and Performance presented this report, which was taken as read.

It was resolved that the Committee:

note the final draft of the Regional Services Plan for 2020/21 was submitted to the Ministry of Health in December 2020 and has been formally approved by the Minister of Health

note there is no requirement to have a Regional Services Plan presented to the Minister for the 2021/22 year

note the progress made on implementing the central region's national and regional priority programmes for the third quarter of 2020/21.

(Moved Oriana Paewai; seconded Muriel Hancock)

7. INFORMATION PAPERS

7.1. Locality Plan Progress Report – Ōtaki

The Locality and Intersectoral Development Manager presented this report, which was taken as read.

There was discussion about the challenges of retaining migrant GPs due to difficulties in resolving residency issues, and agreement that this issue should be bought to the attention of the Ministry of Health. It was noted that the Ōtaki Health and Wellbeing Advisory Group has raised this issue with government agencies and representatives.

It was resolved that the Committee:

Endorse that the Board consider writing to the Ministry of Health to highlight issues faced by migrant GPs in gaining residency.

(Moved John Waldon; seconded Karen Naylor)

note the progress that has been made in relation to Ōtaki Te Mahere Hauora (Health and Wellbeing Plan).

(Moved Materoa Mar; seconded Muriel Hancock)

Materoa Mar and Oriana Paewai left the meeting.

7.2. Committee's Work Programme

The report was taken as read.

It was resolved that the Committee:

note the update on the Health and Disability Advisory Committee's work programme.

(Moved John Waldon; seconded Karen Naylor)

8. GLOSSARY OF TERMS

No discussion.

9. LATE ITEMS

A late item will be discussed in Part Two of the agenda – Provisional Suspected Suicide Statistics MidCentral DHB. It was noted that this item cannot be discussed in the Part One agenda due to the paper containing provisional data from the Coroner's Office which cannot be publicly released.

10. DATE OF NEXT MEETING

Tuesday, 14 September 2021 – Board Room, MidCentral District Health Board, Gate 2 Heretaunga Street, Palmerston North

11. EXCLUSION OF PUBLIC

It was resolved:

that the public be excluded from this meeting in accordance with the Official Information Act 1992, section 9 for the following items for the reasons stated:

Item	Reason	Ref
'In committee' minutes of the previous Health and Disability Advisory Committee meeting	For reasons set out in the agenda of the 16 February 2021 meeting held with the public present	
Health and Disability System Review	To maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by Ministers of the Crown and officials	9(2)(f)(iv)
Serious Adverse Events (SAC 1)	To protect patient privacy	9(2)(a)
Consumer Story – Workshop	To protect patient privacy	9(2)(a)
Provisional Suspected Suicide Statistics MidCentral DHB	To maintain the constitutional conventions for the time being which protect the confidentiality of advice tendered by Ministers of the Crown and officials	9(2)(f)(iv)

(Moved Vaughan Dennison; seconded Lew Findlay)

Part One of the meeting closed at 11.50am

Confirmed this 14th day of September 2021

……..

Committee Chair

MIDCENTRAL DISTRICT HEALTH BOARD

Minutes of the Finance, Risk and Audit Committee meeting
27 July 2021 from 9.00am

PART ONE

COMMITTEE MEMBERS

Tony Hartevelt, Acting Chair (Deputy Committee Chair, Independent)
Oriana Paewai, Committee Chair (via Zoom)
Brendan Duffy, Board Chair
Heather Browning
Vaughan Dennison

IN ATTENDANCE

Board members
Lew Findlay
Muriel Hancock
Materoa Mar

Management
Kathryn Cook, Chief Executive
Neil Wanden, General Manager, Finance and Corporate Services
Darryl Ratana, Deputy Chief Financial Officer
Tracee Te Huia, General Manager Māori Health
Jared McGillicuddy, Internal Audit Manager, Technical Advisory Services
Margaret Bell, Board Secretary

IN ATTENDANCE (part meeting)

Keyur Anjaria, General Manager, People and Culture
Judith Catherwood, General Manager, Quality and Innovation
Graeme Gillespie, Advisor, Commissioning and Contracts
Chiquita Hansen, Interim General Manager, Strategy, Planning and Performance
Lyn Horgan, Operations Executive, Te Uru Arotau
Darren Horsley, Principal Risk Officer
Michelle Riwai, General Manager, Enable New Zealand

APOLOGIES

Simon Allan (Independent)
John Waldon

1. KARAKIA

The meeting opened with the organisational karakia.

2. ADMINISTRATIVE MATTERS

2.1 Apologies

Apologies were received and accepted from Simon Allan and John Waldon. The Acting Chair welcomed Board members to the meeting.

2.2 Late items

There were no late items.

2.3 Register of Interests Update

There were no changes to the register of interests.

2.4 Minutes of the previous meeting

It was resolved:

> *that the Part One minutes of the meeting held on 15 June 2021 be approved as a true and correct record. (Vaughan Dennison; seconded Heather Browning)*

2.5 Matters arising from the previous minutes

There were no matters arising from the previous minutes.

3. PERFORMANCE REPORTING

3.1 Finance Report – June 2021

The Deputy Chief Financial Officer presented the report, which was taken as read. He noted that the Deloitte audit team were on site for the next two weeks. Year-end adjustments had been made, including for the disposal of the Linear Accelerator (LINAC) before it was fully depreciated and provisions to cover redundancies. The amount accrued on the balance sheet for redundancies was aligned to the restructuring change paper.

The Chief Executive advised that written advice had been received that the Government would fund the costs of Holidays Act remediation payments and also of costs associated with determining the amount of remediation.

The Acting Chair and Committee members complimented management on the financial result achieved and acknowledged the work done by the Finance Team.

The Interim General Manager, Strategy, Planning and Performance; General Manager, People and Culture; Advisor, Commissioning and Contracts; and the Principal Risk Officer joined the meeting.

A Committee member noted the increased cost of the recently purchased LINAC. Management explained the variation was due to the exchange rate, capital works for the vendor to manage the installation project, and extended warranty terms.

It was resolved that the Committee:

> *note that the month operating result for June 2021 is a deficit before one-off items of $0.756m, which is $0.700m favourable to budget*
>
> *note that the draft year-end result for June 2021 is a deficit before one-off items of $0.357m, which is $4.557m favourable to budget*

note that the June 2021 year-end COVID-19 related net costs of $0.100m and unbudgeted Holidays Act related costs of $38.485m have been incurred. Including these one-off costs results in a draft year-end deficit after exceptional items of $38.943m, which is $34.029m adverse to budget

note that total available cash and equivalents of $36.489m as at 30 June 2021 is sufficient to support liquidity requirements

endorse the June financial report. (Moved Vaughan Dennison; seconded Heather Browning)

3.2 Finance Report – May 2021

The Deputy Chief Financial Officer presented the report, which was taken as read.

It was resolved that the Committee:

note that the month operating result for May 2021 is a surplus before one-off items of $0.219m, which is $0.735m favourable to budget

note that the year to date result to 31 May 2021 is a surplus before one-off items of $0.399m, which is $3.857m favourable to budget

note that year to date to 31 May 2021 COVID-19 related net costs of $0.100m and unbudgeted Holidays Act related costs of $2.978m have been incurred. Including these one-off costs results in a year to date deficit after exceptional items of $2.680m, which is $0.779m favourable to budget

note that total available cash and equivalents of $45.9m as at 31 May 2021 is sufficient to support liquidity requirements

endorse the May financial report. (Moved Vaughan Dennison; seconded Heather Browning)

The Operations Executive, Te Uru Arotau, Acute and Elective Specialist Services; and the General Manager Enable New Zealand joined the meeting.

3.3 Sustainability Plan

The General Manager, Quality and Innovation presented the report, which was taken as read.

It was resolved that the Committee:

note the progress in the implementation of the Sustainability Plan

endorse the approach and progress made to date on the Sustainability Plan 2020-2023 for the Board's consideration

endorse the Year One benefits reconciliation indicating year to date cash releasing savings of $246,323 have been achieved, for the Board's consideration. (Moved Vaughan Dennison; seconded Oriana Paewai)

4. STRATEGY AND PLANNING

Discussion held in Part Two of the meeting.

5 DISCUSSION/DECISION PAPERS

5.1 FUDPAC Annual Report 2020/21

The Advisor, Commissioning and Contracts and the Interim General Manager, Strategy, Planning and Performance presented the report, which was taken as read. They noted that the acronym 'FUDPAC' had carried over from the original 'Funding Division Performance Audit Committee'.

The Acting Chair noted the large number of contracts created a significant programme of work for FUDPAC.

In response to a question, the Advisor, Commission and Contracts advised that FUDPAC's terms of reference required it to report any high risk audit findings and recommendations to the Finance, Risk and Audit Committee (FRAC) and to report annually to the July FRAC meeting.

It was resolved that the Committee:

> *note the role and function of FUDPAC (Funding Division Performance Audit Committee) and its activity during 2020/21. (Moved Brendan Duffy; seconded Heather Browning)*

The Interim General Manager, Strategy, Planning and Performance; and the Advisor, Commissioning and Contracts left the meeting.

5.2 Controller and Auditor-General's Audit Findings of DHB Audits 2019/20

The General Manager, Finance and Corporate Services presented the report, which was taken as read. The Chief Executive noted the report was brief as the letter from the Controller and Auditor-General was received the same day as the meeting papers were published. Further work would be done if requested by the Committee or Board.

It was resolved that the Committee:

> *note the main findings of the Controller and Auditor-General's DHB Audits from 2019/20. (Moved Brendan Duffy; seconded Vaughan Dennison)*

6 INFORMATION PAPERS

6.1 Internal Audit Programme Update

The Internal Auditor presented the report, which was taken as read.

It was resolved that the Committee:

> *note the update on the internal audit programme status. (Moved Tony Hartevelt; seconded Vaughan Dennison)*

6.2 Clinical Audit Review Findings Update – July 2021

The General Manager, Quality and Innovation presented the report, which was taken as read. Six audits were reported and were at various stages of completion. A further five audits were incomplete and their recommendations would be included in the next report.

The Board Chair commented that the report provided confidence for governors. He asked that the team involved be thanked for the work they were doing.

The Acting Chair noted that recruiting to clinical roles was already challenging and was made more difficult because many clinical staff were working as COVID-19 vaccinators. The General Manager, Quality and Innovation responded that the pressure on the health system and the clinical risks that created were well understood. The ongoing mitigation relied on the expertise and dedication of staff to keep providing quality and safe care. She noted that staff resilience was the biggest risk for both non-clinical and clinical staff.

The Operations Executive, Te Uru Arotau, advised that Emergency Departments (ED) across the country were facing increased demand and workload pressures. MidCentral DHB (MDHB) received a Provisional Improvement Notice (PIN) under Section 36.2 of the Health and Safety At Work Act 2015. In the same week, many other DHBs received PIN notices, including Auckland DHB (11) and Capital and Coast DHB (four). The notices were served for similar reasons. Extra psychosocial and wellbeing support was being provided to MDHB's ED team, including having EAP support on site and a critical incident response team within the DHB. There was also increased engagement between management and ED staff.

The Chief Executive advised that the national Chief Executives held weekly meetings on transition issues. These meetings had also focused on the increased pressure faced by EDs around the country and recruitment. Discussions would be held with the Ministry about the ED issue as well as seeking Government support to bring workers into the country (Visa issues) and granting residency to workers already here.

A Board member asked what the Board could do to support the executive leadership team and other non-clinical staff with their workload. Management asked that the Board prioritise work requests to focus on critical tasks, which would allow the best use of limited resources.

A Committee member asked whether the issues facing the primary health sector and GP services were leading to increased ED presentations. Management replied that people presenting to ED were in an acute state with complex needs. It was not possible to understand whether their acute health state was due to delays in being able to see a GP. Where appropriate, patients were referred to a primary care team.

It was resolved that the Committee:

> *endorse the progress of the clinical audit recommendations. (Moved Oriana Paewai; seconded Vaughan Dennison)*

6.3 Enterprise Risk Update

The Principal Risk Advisor presented the report, which was taken as read. He noted that risk frameworks had been developed for the health sector transition, including human resources; leadership and governance; and business continuum. The annual risk workshop following the August Board meeting would focus on the current state, the future state and the transition.

The Chief Executive noted that a first draft of MDHB's transition plan would be presented to the August Board meeting ahead of the risk workshop.

A Committee member noted the rise in the residual risk rating for Risk ID 728 Infrastructure and requested that the risk appetite be reviewed as part of the planned workshop in August.

In response to questions, the Chief Executive noted that the transition was being led by the Department of Prime Minister and Cabinet (DPMC) and the Treasury. Chief Executives met regularly with the Transition Unit. New Boards for Health New Zealand and the Māori Health Authority were expected to be in place by the end of September 2021. Chief Executives would then be recruited. The Transition Unit had no decision-making powers, so the new Boards and Chief Executives would play a critical role. Legislation was still being drafted and the transition was expected to take between two and five years.

The FRAC Chair advised that iwi see the transition as an opportunity. They had engaged with and presented to the DPMC Transition Unit on what they wanted to see. This would be the focus of the Board and Manawhenua Hauora meeting on 23 August.

The Interim General Manager, Strategy, Planning and Performance and the Director of Strategy joined the meeting.

The Acting Chair noted the organisation should focus on handing over a working organisation.

The Board Chair acknowledged the value of weekly Zoom meetings for all DHB Chairs with the Minister of Health. It was reassuring that other DHBs faced similar challenges and frustrations. The Minister's expectation is that DHBs deliver on their agreed programmes and the requirements outlined in the Minister's Letter of Expectations.

It was resolved that the Committee:

note the updates of all MidCentral District Health Board (MDHB) enterprise risks that have undergone planned periodic review

note the current status of Enable New Zealand strategic risks. (Moved Brendan Duffy; seconded Vaughan Dennison)

6.4 Enable New Zealand Enablement Programme

The General Manager, Enable New Zealand presented the report, which was taken as read. She noted that some projects were 'on hold' to enable resources to be focused on the implementation of the JDE replacement.

In response to a question, the Chief Executive advised that Enable New Zealand is currently an operating division of MDHB. All DHB subsidiaries, including Enable NZ, Allied Laundry and Technical Advisory Services, would transfer to Health New Zealand. A report will be provided to the Committee to give advice on options for Enable New Zealand to enable it to be maintained as a distinct unit as the health reforms are being implemented.

It was resolved that the Committee:

note the Enablement Programme update to 30 June 2021. (Moved Vaughan Dennison; seconded Heather Browning)

The General Manager, Quality and Innovation; Principal Risk Officer; and the General Manager, Enable New Zealand left the meeting.

6.5 Holidays Act Compliance Project Update

The Deputy Chief Financial Officer presented the report, which was taken as read. The Ministry of Health (the Ministry) had confirmed they would meet all costs associated with determining the remediation and the costs of remediation payments.

The Chief Executive advised that issues around RMO (Resident Medical Officer) leave transfer between DHBs and defining a 'working week' were close to resolution. The Ministry would not release funding for remediation payments until they were satisfied (through the KPMG Programme Management Office) that a consistent process had been applied across all DHBs. It was noted that remediation payments would be taxed at the rate applicable when the payment was made.

It was resolved that the Committee:

note the update on the Holidays Act Compliance Project, and the ongoing work being carried out to resolve non-compliance

note that the accrual of liability as at May 2021 is $12.297m with a year to date spend of $1.677m, and a further $2.636m accrued towards rectification costs for this financial year. (Moved Tony Hartevelt; seconded Brendan Duffy)

6.6 Health, Safety and Wellbeing

The General Manager, People and Culture presented the report, which was taken as read. The increased workload and pressure staff were working under was acknowledged. However, when compared to other DHBs, MDHB's overtime rate was low and in terms of nursing vacancies, MDHB, while not the lowest, was not an outlier.

A Committee member commented that it was reassuring to learn that MDHB was doing well when compared to other DHBs.

The Board Chair advised he had sat in on one session of the Incident Management Team dealing with events from increased pressure on hospital services. He complimented the team involved and noted the efficient process used to deal with the issues.

It was resolved that the Committee:

note the quarterly Health, Safety and Wellbeing report

endorse the quarterly Health, Safety and Wellbeing report for submission to the Board

endorse the Health and Safety statement for approval by the Board. (Moved Vaughan Dennison; seconded Tony Hartevelt)

The General Manager, People and Culture left the meeting. The Chief Digital Officer joined the meeting.

6.7 Committee's Work Programme

The General Manager, Finance and Corporate Services presented the report, which was taken as read.

It was resolved that the Committee:

approve the changes to the Committee's annual work programme. (Moved Brendan Duffy; seconded Heather Browning)

7. GLOSSARY OF TERMS

No discussion required.

8. LATE ITEMS

There were no late items for Part One.

9. DATE OF NEXT MEETING

Tuesday, 7 September 2021 – Board Room, MidCentral District Health Board, Gate 2 Heretaunga Street, Palmerston North

10. EXCLUSION OF PUBLIC

It was resolved:

that the public be excluded from this meeting in accordance with the Official Information Act 1992, section 9 for the following items for the reasons stated:

Item	***Reason***	***Ref***
'In committee' minutes of the previous meeting	For reasons set out in the meeting agenda of 15 June 2021	
Final Draft Budget and Annual Plan 2021/22	To maintain the effective conduct of public affairs through free and frank expression of opinions	9(2)(g)(i)
Special audit: Provider contract renewal and missed payment review	To protect negotiations, including commercial and industrial	9(2)(j)
Review of digital project procurement and delegations approach	To protect negotiations, including commercial and industrial	9(2)(j)
Purchase of anaesthetic machines, anaesthetic patient monitors and PACU patient monitors	To protect negotiations, including commercial and industrial	9(2)(j)
Draft Capital Expenditure Plan 2021/22	To maintain the effective conduct of public affairs through free and frank expression of opinions	9(2)(g)(i)

(Moved Tony Hartevelt; seconded Vaughan Dennison)

Part One of the meeting closed at 11.10am

Confirmed this 7th day of September 2021

……
Chairperson

BOARD REPORT

For:

	Approval
	Endorsement
X	Noting

Key questions the Board should consider in reviewing this paper:

- Is the Board confident that the discussion points of Manawhenua Hauora are being partnered and supported where appropriate?
- Does the Board support that Manawhenua Hauora seeks to find its fit with the reforms and lead to shape what that looks like?
- Does the Board have any follow up points for either the Organisational Leadership Team or Manawhenua Hauora?

To	Board
Author	Tracee Te Huia, General Manager, Māori Health
Endorsed by	Kathryn Cook, Chief Executive
Date	29 July 2021
Subject	**Manawhenua Hauora Chair's Report – MidCentral DHB's Response**

RECOMMENDATION

It is recommended that the Board:

- **note** the report from the Manawhenua Hauora Chair on the Manawhenua Hauora hui held in July 2021.
- **note** the MidCentral District Health Board's (MDHB) response to the Chair's report.

Strategic Alignment

This report is aligned to the DHB's 10-year strategy and Ka Ao, Ka Awatea Māori Health Strategy.

1. PURPOSE

To provide the Manawhenua Hauora Chair's report on the July 2021 Manawhenua Hauora meeting and advise the Board of management's responses to issues raised in the Chair's report.

2. SUMMARY

The report covers the following:

- Iwi updates
- Transition Unit presentation
- National Hauora Coalition
- Maori Data Sovereignty
- Draft budget 2021/22
- Strategic property plan
- Kia eke panuku, kia eke Tangaroa, Pathways to Success

3. MDHB'S RESPONSES

Iwi updates

We are delighted to have Kelly Bevan for Ngāti Raukawa ki te Tonga join Manawhenua Hauora. As chair for Ngāti Raukawa, Kelly brings good knowledge of the developments for iwi across the areas of focus. Lena Kingi brings strong expertise as a senior administrator. Lena will work into the Pae Ora team and will provide administration support for Manawhenua Hauora, MALT, Whiti ki te Uru and the Board-to-Board meetings.

Transition Unit presentation

Mara Andrews provided strong insight into the developments of the Transition Unit on aspects related to Māori health. The key messaging was related to the establishment of iwi Māori partnership boards in the reforms. General Managers Māori Health, Tumu Whakarae, are working with the Transition Unit to consider the focus and functions of the Iwi Māori Partnership Boards (IMPBs) and to provide existing information related to instruments such as terms of reference, work plans and resourcing. Once boundaries are agreed, it is expected the four regions will be announced. This is a clear opportunity for iwi to work in a more conducive manner to their boundaries and needs. MDHB will continue to work with Manawhenua Hauora on its aspirations to become self-managing. As we take advice from the Ministry of Health and from the Transition Unit we will progress and develop within the advice.

National Hauora Coalition

An expression of interest was received by the MDHB's Chief Executive, from the National Hauora Coalition (NHC) to establish in the MidCentral DHB district. The NHC is a primary health care organisation established in 2011. Its grouping is made up of Māori service providers who seek to deliver primary and community services to the regions of Auckland Central, Auckland South, Auckland East, Auckland West and North-west, Waikato and Whanganui. Manawhenua Hauora's view is that the district's relationships across THINK Hauora, MDHB and Manawhenua Hauora is strong and ready for the change within the sector. In addition, MDHB has a policy to have only one primary health organisation in this district. Therefore, a response letter was sent in July declining the offer.

Draft Budget 2021/22

A presentation was provided to Manawhenua Hauora by the MDHB's Chief Financial Officer on the DHB's budget for this financial year. Manawhenua Hauora was delighted with the increase for iwi and Māori provider services, totalling an investment of $23m for services to Māori within the hospital and community. More focus was placed on the new role of IMPBs signing off on budgets and planning in the future. MDHB will keep iwi informed on any major projects and or investment through to 1 July 2021.

Strategic Property Plan

Representatives will be sought through Manawhenua Hauora for the major building projects within DHB. Once the chair has confirmed representatives, they will be included into the terms of reference and provided with details to engage them in the kaupapa. We look forward to iwi input into the strategic developments of hospital and secondary services.

Kia eke panuku, kia eke Tangaroa, Pathways to Success

The presentation provided to the Transition Unit in July will be presented to the Board-to-Board meeting on 23 August 2021.

Meeting held 12 July 2021

IWI UPDATES

Kelly Bevan Ngāti Raukawa ki te Tonga and Lena Kingi administrator for Manawhenua Hauora were welcomed to the roopu.

TRANSITION UNIT PRESENTATION

Mara Andrews Senior Advisor to the Transition Unit Maori Health, provided Manawhenua Hauora with a presentation on iwi/Māori Partnership Boards. At present there are 17 iwi Māori partnership boards (IMPBs) established across four regions these being Northern, Midlands (Te Manawa Taki), Central and Southern. These boards have varying roles and responsibilities established in terms of reference, MoUs, partnership manuals and workplans. Some boards are currently considering establishing as legal entities to enable them to self-manage. Manawhenua Hauora support this approach and is looking into becoming a legal entity. Consultation was sought on the following:

Proposed membership of IMPBs in the new structure for consultation

- Each IMPB must include/invite all Manawhenua from the locality/district
- Each IMPB should invite and include mataawaka/urban Māori representation to reflect their Kaitiaki/Manaaki role as manawhenua. This is best manifested in each area to suit and some areas may already be including mataawaka
- Each IMPB could add specialist hauora/clinical/lived experience expertise be added to the IMPB (could be from within or external to the IMPB coverage area)
- Minimum/maximum member numbers for each manawhenua iwi member shall be determined by the IMPB members through their Terms of Reference (e.g., max 2 members per iwi or for large iwi? 2 per hapū or locality?). Voting rights shall be similarly determined (guidelines can be provided and some existing tools carried over)

Cor functions of all IMPBs: strategic governance

1. CURRENT STATE/WHĀNAU ENGAGEMENT – engage whānau & hapū, give them a voice and assess current state of Hauora Māori in their rohe
2. SETTING PRIORITIES: IMPB annual Letter of Expectations* for negotiation with Health NZ (HNZ) and Māori Health Authority (MHA) which would cover all localities/areas in their rohe – and which includes:
    - Strategic Māori health outcome priorities for the locality/region

- Service level priorities (e.g., across life-span or specific services)
- Priorities for Kaupapa Māori innovations, services, technologies
- Broader observations on wellbeing/social determinants of health
- Unique or significant issues: hot spots, locality priorities, crisis response

3. REVIEW: Engage and review Locality/District and Regional Health Plans developed by HNZ/MHA for alignment with the Letter of Expectations
4. APPROVE: Sign/endorse Locality/Regional Plans* (escalate where not in agreement)
5. MONITOR: With the HNZ/MHA, monitor the performance of services in the locality/district and region against the agreed IMPB priorities in the plan(s)*
6. ACCOUNTABILITY: Produce Annual Reports* of IMPB activities for whānau and for partners

Other possible functions of IMPBs
These could be commissioned separately from each IMPB as negotiated locally:

- INTERSECTORAL COLLABORATION: Partner with HNZ/MHA Regional Commissioners in cross-sectoral collaboration/advocacy with MHA/HNZ (e.g., Oranga Tamariki, Ministry for Social Development, Corrections, Police, Kainga Ora, ACC, Ministry for Justice) to support focus on social determinants of health by HNZ and MHA
- COMMUNICATIONS: Champion communications and campaigns (e.g., promoting messages re Covid amongst their constituencies for instance) developed by Public Health Agency/HNZ/MHA in the interests of public health protection and health promotion
- DATA SOVEREIGNTY: Oversight of Māori data sovereignty requirements – *data held by MOH, MHA & HNZ*
- TRAINING AND EDUCATION: Provide education to HNZ region/locality/mainstream providers about manawhenua, aspirations and history. Education on cultural safety, institutional bias, and racism from a manawhenua perspective
- CRISIS OR RISK MANAGEMENT: supporting HNZ and MHA with specific health or provider risks or crises within the rohe
- INNOVATION: Bottom-up innovation initiatives that add value to the Māori sector
- PROVIDER CAPABILITY & MARKET DEVELOPMENT: Capacity needs assessment developed. Convening regular provider hui to build peer support, leadership pathways, joint learning opportunities. Strengthening mainstream providers serving Māori including hospitals through education on tikanga best practice guidelines and equity programmes of work
- MĀORI WORKFORCE DEVELOPMENT STRATEGIES: Promoting health careers and pathways; growing a different type of future Māori health workforce?

PO BOX 1341 MAXWELLS
PALMERSTON NORTH

NATIONAL HAUORA COALITION

Chief Executive Kathryn Cook requested the advice of Manawhenua Hauora on an Expression of Interest by the National Hauora Coalition to establish services in the MidCentral district. The consensus for those iwi who understood the National Hauora Coalitions business was to respectfully decline as these services wouldn't be conducive to the system established in this district. The relationships between THINK Hauora, DHB and Manawhenua bodes us well for the reforms and an additional provider would only confuse our developments.

MAORI DATA SOVEREIGNTY

An update was provided on the 3 DHB policy and guideline developed which will be signed off by Central Regions CEOs. Once this is completed it will be submitted to Iwi Partnership Boards for endorsement. Manawhenua Hauora looks forward to seeing these documents in due course.

DRAFT BUDGET 2021/22

The draft budget was presented to Manawhenua Hauora with a robust discussion on the allocation and deficit. Manawhenua Hauora expected the whole budget be presented so that they could advise accordingly. We were delighted to see that the Executive team have worked hard to keep the Māori health investment in the budget given the fiscal constraints. In our new role for signing off health budgets in the new structures of HNZ and MHA we look forward to more ability to have input into budget decision making for our population.

STRATEGIC PROPERTY PLAN

A presentation was received on the hospital facilities plan including the new mental health facility, acute services block, and cancer centre. Manawhenua Hauora was consulted on the developments and it was suggested a Manawhenua Hauora representatives be established on the governance steering committee. Representatives will be provided to Neil Wanden, Chief Finance Officer once these are endorsed.

PO BOX 1341 MAXWELLS
PALMERSTON NORTH

KIA EKE PANUKU, KIA EKE TANGAROA, PATHWAYS TO SUCCESS

A presentation will be provided to the transition unit on what a potential prototype could look like for this district led by iwi. All agencies have been invited to participate and make comment on the proposition. This presentation will be provided to MDHB at the Board-to-Board meeting scheduled for the 23 August 2021. We look forward to your positive feedback.

Mā pango mā whero
Ka oti ai te mahi
By the cooperation and combining efforts
We'll achieve our aspirations

Deputation

17 August 2021

Printed from Stellar by
Margaret Bell <margaret.bell@midcentraldhb.govt.nz>

New Zealand College of Midwives
TE KĀRETI O NGA KAIWHAKAWHANAU KI AOTEAROA

Manawatu
Sub-region

29 June 2021

Board Members

MidCentral District Health Board

Via email: BoardSupport@midcentraldhb.govt.nz

Reason for letter: Midcentral region midwife representatives requesting meeting with the board members.

Tēnā koutou – MidCentral District Health Board members; John Waldon, Brendan Duffy, Heather Browning, Vaughan Dennison, Lew Findlay, Muriel Hancock, Materoa Mar, Gail Munron, Karen Naylor, Oriana Paewai, Jenny Warren.

Representatives for the midwives of the Midcentral region formally request to meet with the Midcentral Board to discuss reasons for our collective presence at the board meeting on the 25th May 2021.

The crisis affecting the regional maternity system and midwifery services must be addressed. As service providers to wāhine, pēpi and whānau, midwives stand collectively and united. We are aware that this crisis can not be fixed overnight however, we believe through the implementation of an agreed plan which is solution focused with realistic time frames, then effective change is inevitable.

It is our belief that Midcentral DHB leaders be held accountable to the Board for monitoring the progress or non-progress of the current maternity services. The importance of open and honest lines of communication are vital to achieve positive outcomes for the maternity services. .

Midwives are concerned with the transparency of information presented to the board as to reasons for this crisis: women becoming more complicated, LMC handing over for epidural care – for which the DHB is funded under the Secondary care Service specifications, or a staffing shortage. Whilst some of these elements may be true we believe that some key issues have been overlooked such as the reasons why the mass exoduses of midwives has occurred over the last two years. One solution to exploring the reasons may be partially determined through effective exit interviews, surveys, and personal communications with the Executive team. Through this the board can be fully apprised as to the underlying causes for shortages in employed midwives, and subsequently, the inability to staff both secondary and primary units.

We wish to assure the Board that the regional midwives are committed to supporting the newly appointed Director of Midwifery (DoM) who will advocate for midwives as well as being the voice of hapū māmā, whānau, the public and the midwives of the district. However there is a consensus within the midwifery workforce that any strategic role such as this, requires the midwifery profession to be involved in the appointment process of the DoM. We consider this role as a midwifery leader to be vital to effective change occurring within the Midcentral DHB maternity services. The role requires the DOM to have a significant depth and breadth of experience and knowledge of the NZ maternity system.

New Zealand College of Midwives
TE KĀRETI O NGA KAIWHAKAWHANAU KI AOTEAROA

Manawatu
Sub-region

We wish to reassure the board members that midwives are passionate about the profession and are strong advocates for wāhine, pēpi and whānau and the midwifery profession as a whole. We are committed to the future of the midwifery and maternity services in the Midcentral district.

Ngā mihi

Nikki Murtagh

Seconded by Jayne Waite

Co-Chairpersons

NZCOM Manawatu Sub Region.

14 June 2021

Performance reporting

17 August 2021

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Margaret Bell <margaret.bell@midcentraldhb.govt.nz>

BOARD REPORT

For:

	Approval
	Endorsement
X	Noting

Key questions the Board should consider in reviewing this paper:

- Does the report provide a useful update on local, regional and national matters?
- Are there any additional matters that should be included as routine items in future updates?

To	Board
Author	Kathryn Cook, Chief Executive
Endorsed by	
Date	10 August 2021
Subject	**Chief Executive's Report**

RECOMMENDATION

It is recommended that the Board:

- **note** the update of key local, regional and national matters.

Strategic Alignment

This report is aligned to the DHB's strategy and key enabler, 'Stewardship'.

1. PURPOSE

To provide the Board with an update of key local, regional and national matters. No decision is required.

2. LOCAL MATTERS

2.1. Financial update

The result for the month of July was a surplus of $0.303m. This is an unfavourable variance of $0.276m to the draft budget of $0.579m surplus.

2.2. Laurie McCool Learning Centre

Following a formal blessing on 22 July 2021, the Laurie McCool Learning Centre is now fully operational. This facility is located in the area previously used by the Clinical Records Department and provides the DHB with two new lecture theatres and a small meeting room. Laurie McCool was a supporter and patron of the Palmerston North Hospital, as well as a former patient. He made charitable bequests of over $6 million, including a donation to the Palmerston North Hospital Medical Trust. Trustees made $280,000 available to provide the technology requirements for the centre, which include Zoom capability, laptops and wi-fi.

The staff transition into this area is part of the SPIRE project. Areas left vacant as a result of the move will support the expansion of theatre, endoscopy services and the new cardiac catheterisation laboratory.

2.3. Provisional Improvement Notice

On 13 July 2021, MDHB was served a Provisional Improvement Notice (PIN) by a health and safety representative working in the Emergency Department (ED). The PIN was served under section 36.2 of the Health and Safety at Work Act 2015. As required by the Act, the notice was displayed in the ED. The PIN referred to staff fatigue and frustrations caused by increased demands on the service, coupled with the inability to redistribute patients to other areas of the hospital due to the demand for inpatient beds.

A group comprising DHB management, clinical staff and union delegates from the NZ Nurses Organisation (NZNO) and the Association of Salaried Medical Specialists (ASMS) agreed to an action plan to ensure safe clinical staffing during periods of high demand in the ED. All the actions from the PIN notice have been completed or have timelines for completion. The PIN notice has been lifted by the health and safety representative and unions.

2.4. Consumer Engagement Day

The first in a series of education and networking events for the Consumer Council and the wider consumer network was held at Caccia Birch House on 29 June. The events are designed to support consumer engagement and build relationships and capacity within the MidCentral District Health Board's (MDHB) consumer network. Three new members of the Consumer Council were welcomed at the hui.

2.5. Cardiac MRI Scan

The first cardiac MRI scan was successfully carried out at Palmerston North Hospital on 26 July 2021. Because this procedure was able to be carried out in a timely manner, the patient did not need to be transported in an acute state to Hutt Hospital. The commencement of cardiovascular magnetic resonance (CRM) imaging will support MDHB's interventional cardiology service.

2.6. Patient Letters Update

More than 100 automated letters are used as part of webPAS (patient management system) to advise patients of clinic bookings or the outcomes of their referral. An improvement project group was established in 2020 and a team of stakeholders and consumers has analysed the existing letter set. It was agreed that more 'plain language' was needed to make the letters more patient and whānau friendly.

An external provider was engaged to rewrite the letters and ensure the message was clear and that clinical requirements of the communication were still included. Following a rigorous sign off process, the first batch of the letters was released into the live webPAS system on 28 July. The plan is for the entire webPAS letter suite to be rewritten.

2.7. Dr Shane Reti – National MP

A request has been received from Dr Shane Reti, National MP to visit Palmerston North Hospital on Wednesday 18 August 2021. Dr Reti has asked to discuss the Birthing Centre and to have a brief tour of the hospital. The Minister of Health's office has been notified of this request. The Chief Executive and Board Chair will host this meeting.

2.8. Major Projects

2.8.1. Emergency Department Observation Area (EDOA)/Medical Assessment and Planning Unit (MAPU) Pods

Design, construction and consenting will be undertaken in two stages to expedite the project. Stage One is focused on the foundations and below, with Stage Two focused on above foundation works. The detailed design for Stage One has been completed and building consent lodged on 9 August, two weeks later than programmed. Tender documents have been prepared and construction is expected to commence on 1 October 2021. The detailed design for Stage Two will be completed early September.

2.8.2. SPIRE (Surgical Procedural Interventional Recovery Expansion)

The relocation of services to free up space for SPIRE was concluded in July and a formal blessing of the Laurie McCool Learning Centre was held on 22 July 2021. The detailed design process for Stage One is complete. Stage Two will commence this month. The procurement of the main contractor continues and Registrations of Interest (ROI) received. Stage One has been issued for tender and lodged with the Palmerston North City Council for building consent. The procurement of the Cath Lab equipment is in its evaluation phase. A recommendation is expected to be provided early August to meet the design programme. The project programme (timeline) has not changed, with work to be completed by December 2022. The estimated construction budget has risen by approximately four percent from the developed design to detailed design phases. As SPIRE is being done within the current hospital and theatre footprint, there will be an impact on theatre activity. This was known and understood at the outset of the project and minimising theatre downtime has driven the project delivery strategy. A transition plan has been developed and is under discussion with surgical leads. Changes have been proposed to Stage One to allow continuity of one endoscopy room until the new procedure rooms 1 to 3 are commissioned. Access to a fifth theatre at Crest Hospital is a key part of the transition plan and discussions with Crest are ongoing. The potential to split Stage Two into two phases to keep operating theatres open will be explored with the contractor once appointed. There will be a meeting soon, facilitated by Dr Andrew Connolly, to discuss the concerns of medical staff and options for these to be addressed. The Board will be briefed on this at the next Board meeting.

2.8.3. Fluoroscopy

The fluoroscopy machine has been ordered and is expected to be commissioned by the end of 2021. The decommissioned machine has been removed. A preliminary design has been issued for the design/build component of the project. This is expected to be finalised by the end of August and construction work will then begin.

2.8.4. Acute Mental Health Unit

The Mental Health and Addiction Service has carried out detailed analysis of the model of care and patient journeys, which will be incorporated in the design. Membership of the project's steering committee and project control group has been refreshed to support the model of care approach. A stakeholder workshop will be held in August to work through the preliminary design and identify any issues. The preliminary design is expected to be completed mid-September. RCP, an independent project management company, has been appointed to manage the project.

2.9. COVID-19 Vaccination Planning

COVID-19 vaccination continues to be delivered against the plan, working toward fully vaccinating MDHB's eligible (16 years and over) population of 145,000 individuals. MDHB remains above target for delivery of total numbers. The programme successfully scaled from 7000 to 10,000 per week over the last six-week period. At the peak of scheduled delivery, more than 12,000 vaccinations will be delivered each week by a range of providers. The limited vaccine supply in early July had no impact on local delivery and no appointments needed to be rescheduled.

The capacity of the district to reach this target for COVID-19 vaccinations continues to be built, with 34 active delivery sites registered with the Ministry of Health (the Ministry). An average of 11 iwi sites are delivering vaccinations each week. Delivery across the various locations span broad hours, including after hours clinics and weekends to provide optimum accessibility and ensure a range of options are available to residents – especially those in rural and remote locations. More than 21,000 doses have been delivered at the Palmerston North Central site; 1500 delivered at Māori and iwi providers or via mobile Māori clinics; 30,000 delivered by GP teams and more than 9000 delivered in community pharmacy settings.

The first rural-delivered clinic in Eketāhuna was a very successful iwi-led event which attracted positive national media attention. This was a collaborative venture with local iwi, Eketāhuna Health Centre, Tararua Health Group, the primary health organisation and the DHB. This will repeated in six weeks' time with more first doses made available as well as the second dose for the more than 300 whānau who attended the first event.

Transition to the national booking system, 'Book my vaccine' was successfully achieved in early July, with only a few minor booking transfer issues. This system enables direct online or telephone bookings for the majority of the MDHB vaccination clinics. A few local general practice teams continue to use their own booking system. These practices are signposted through the 0800 number, online booking and HealthPoint.

Group Three vaccinations are well underway, with all eligible people having received an invitation by 23 July. With improvements in the data set now available, the capability is now available to track progress against the larger rohe populations in Groups Three and Four. Invitations for Group Four vaccinations have started, with sequential age bands planned to increase. The total MDHB population in this group is around 80,000. Invitations are being sent from a data set managed by the Ministry and provided via text, email or letter. All of these communications provide the recipient with a range of methods to book, including online and via an 0800 number. Invitations will be issued every two weeks or when the Minister approves the next age band.

Communications are supplemented by national and local media across online social media and through newspaper advertisements. MDHB is finalising local enhanced invitations, with a focus on priority populations. Those eligible in Groups One, Two or Three who have not yet booked are being actively encouraged to do so. Aged care residents received their completed doses in early July. Good progress is being made in delivering vaccinations to people with a disability via a range of locations, such as planned low sensory clinics at the Palmerston North Central site. A dedicated disability coordinator is supporting this mahi.
The MDHB's vaccinator and administration workforce has continued to increase to match the scale of the programme. A plan has commenced to support the training of the supervised workforce (referred to as COVID vaccinators). The workforce stream is reviewing the approach to identify ways to supplement the existing workforce and ensure appropriate ethnicity ratios.

Discussions are being finalised nationally regarding the delivery approach in workplaces. Locally, a plan is being finalised to deliver to workplaces with high numbers of Māori and Pasifika staff and will commence in the next few weeks. The delivery of vaccines for 12 to 15-year-olds is also being developed in partnership with the education sector. Local clinical advice and input is being incorporated into the national approach. The timing of delivery has yet to be confirmed by the Ministry.

The following table provides an update of doses received by MDHB residents anywhere, and those delivered in MDHB as at 1 August 2021.

		All ethnic groups as at 1/8/21 (% of 16+ population[1])	Maori as at 1/8/21 (% of 16+ population[2])	Pacific as at 1/8/21 (% of 16+ population[3])
MDHB residents vaccinated anywhere	Received first dose	50,264 (33.6%)	5,217 (19.3%)	1,092 (25.9%)
	Received two doses	34619 (23.1%)	3,777 (14.0%)	762 (18.1%)
Vaccinations delivered in MDHB	Received first dose	46,858	4,506	929
	Received two doses	31,873	3,199	630
	Total Doses Administered	**78,731**	**7,705**	**1,559**

[1] 149,580 population, [2] 26,970 population, [3] 4,220 population

2.9.1. Equity

A clear focus on equity has been built into MDHB's programme, with the weekly receipt of progress against the agreed targets. Current achievement against target is 61 percent for Māori and 144 percent for Pasifika. MDHB's Māori targets are set at between 1500 and 1600 per week through to the end of August, as agreed with the Ministry. These are reviewed weekly alongside the numbers forecast across Māori clinics. It is expected the targets are achievable if all vaccination provider sites have a focus on prioritising Māori and this is a priority strategy area.

Specific additional investment has been provided for iwi and Māori to enable navigation and coordination resources to be in place. Of the 27,000 Māori in this region, 19 percent have had at least one dose and 14 percent are completely vaccinated. In addition to prioritising Māori through Group Two (kaumatua over 50 and their whānau) and through GPs, MDHB has utilised two approaches to vaccinate Māori, in addition to all the other clinics. Ongoing clinics have been established at eight sites and bespoke community events in communities with high Māori populations are being prioritised. Approaches such as with Eketāhuna and bespoke clinics are expected to support this mahi. Community events are planned for Foxton and Shannon, with these populations having 35 percent and 40 percent Māori population respectively.

It is understood that MDHB is tracking below its target for Māori but the team is satisfied and confident with the speed which things are happening and the approach of working with iwi and Māori providers to vaccinate Māori. There is good locality coverage across the region and Māori who would otherwise not be open to receiving a vaccine are being reached. This work is supported by 11 navigation and coordination roles working within all iwi providers across all localities. As an example, an iwi is knocking on doors and going into people's homes to encourage people to have a vaccination. The feedback is that this experience is appreciated by people.

3. REGIONAL MATTERS

3.1. Regional Services Plan

The region agreed five priority work programmes as integral to this year's Regional Service Plan.

- Planning for Sustainable Complex Care (Tertiary) Sustainability – discontinued and will be developed nationally as part of the health sector reform transition process.
- Developing Regional Single Systems of Care – Prototyping Orthopaedics (SSOC)
- Developing a Plan for Regional Specialist Mental Health and Addiction Services (MH&A)
- Implementing the Regional Cardiology Plan
- Developing a Regional Frailty Model of Care (A-RF).

3.1.1. Single System of Care Update

Synergia's final report was presented to the Regional Partnership Group (RPG) on 2 August. Technical Advisory Services (TAS) has developed a discussion paper to test the concept of a regional triage hub for primary care referrals. This reflects the central component of a single system model and responds to several of Synergia's key recommendations. A Programme Steering Group will be established to oversee the feasibility and scoping phase which incudes developing a detailed programme implementation plan and a business case to be approved by the RPG. This work involves a significant amount of stakeholder engagement and is expected to take between six and eight months to complete.

3.1.2. Mental Health and Addictions Services Update

A Programme Steering Group workshop on 13 August will refine the focus and develop the work programme. MDHB's Operations Executive, Te Uru Rauhī and Interim General Manager, Strategy, Planning and Performance are members of the steering group. The feasibility and scoping phase is expected to take between four and six months to complete.

3.1.3. Regional Cardiology Plan Update

Regional Cardiac Network Clinical Leads will meet on 12 August to review the latest data modelling, assess the clinical risk and financial viability of proposed catheter laboratory developments in Hawke's Bay and MidCentral DHBs. Discussions are taking place with the Chair of the Interventional Working Group of the Cardiac Society (NZ) to determine a clinician to provide further advice.

3.1.4. Frailty Model of Care Update

Francis Health presented 'Achieving Kaumatua Ora' to the RPG in July. This is a co-developed, aspirational frailty framework, supported by a descriptive, outcomes-based model of care. To support implementation, a time-limited Programme Steering Group will be established.

4. NATIONAL MATTERS

4.1. National Chief Executives meeting – 11 and 12 August

A meeting of national Chief Executives and a Combined Chief Executives and Chairs meeting was held on 11 and 12 August in Wellington. The Chief Executive and Board Chair will provide a verbal update at the meeting.

4.2. Association of Salaried Medical Specialists (ASMS)

Bargaining continues between DHBs and the Association of Salaried Medical Specialists (the union covering senior doctors). DHBs have tabled an offer to ASMS, who have sought a stop work meeting of up to two hours, as provided for in the Senior Medical and Dental Officers Collective Agreement. The MDHB stop work on 4 August will provide ASMS with an opportunity to update their members on progress toward settling the collective agreement and to seek feedback on the offer from their members. It is understood the stop work meeting will also discuss potential strike action. Arrangements are being made to ensure essential activities are maintained during the period of the stop work meeting.

4.3. Resident Doctors' Association (RDA) Collective Bargaining

The DHBs' offer to settle this multi-employer collective agreement (MECA) has been ratified by RDA members. DHBs are now working through the implementation plan and the new terms will be implemented as soon as possible. The new MECA will expire on 31 March 2024.

4.4. NZ Nurses Organisation (NZNO) Strike

On 16 July, NZNO agreed to take the DHBs' revised offer to their members for ratification and the strike notice for 29 and 30 July was withdrawn. On 29 July, DHBs were advised that NZNO members had rejected the offer. Engagement between the bargaining teams have recommenced. MDHB is preparing for strike action on Thursday 19 August (eight hours) and on Thursday 9 and Friday 10 September (24 hours) if further negotiations do not result in an acceptable offer.

4.5. Midwifery Employee Representation and Advisory Services (MERAS)

Bargaining between the DHBs and MERAS continues. DHBs are working through the required approval process and expect to table an offer in early Augusts. In the meantime, MERAS has issued strike notices across all DHBs. MDHB's notice is for an eight-hour strike on 11 August 2021, from 11am to 7pm. Contingency plans are in place and the provision of Life Preserving Services during the strike period are being agreed with MERAS.

4.6. Pay Equity

The following progress has been made by the District Health Board (DHB) negotiating team across various workforces and unions with pay equity claims.

- The agreement reached between DHBs and the Public Service Association (PSA) in November 2020 has now progressed to the next stage. This includes 'mapping' all clerical/administration roles so they can be accurately placed within agreed salary ranges based on position descriptors. This exercise is being led nationally and is expected to be completed by the end of August 2021.
- Negotiations with NZNO, the Association of Professional and Executive Employees (APEX), PSA (Allied and Scientific, and Nursing roles) and the MERAS unions continue on pay equity claims. An interim adjustment for nurses and midwives has been included by the DHBs in their settlement offer to NZNO.

5. ORGANISATIONAL LEADERSHIP TEAM AND STAFFING MATTERS

5.1. Appointment of Deputy Commissioner to the Health and Disability Commission

Dr Vanessa Caldwell, Clinical Executive, Te Uru Rahuī, Mental Health and Addiction Services has been appointed Deputy Health and Disability Commissioner. Vanessa starts her new role on 6 September 2021.

Vanessa has worked in mental health and addiction services for 28 years, including roles as a psychologist and service manager in residential and outpatient services, and leading national workforce programmes. Since joining MDHB in April 2018, she has been involved in progressing the acute facility new build, transforming the services to an integrated care model and responding to the national mental health inquiry.

Deputy Health and Disability Commissioners are appointed by the Governor-General on the recommendation of the Minister of Health. Vanessa has been appointed for a term of five years.

5.2. Long Service Awards

The Long Service Awards ceremony scheduled for Tuesday 20 July 2021 was postponed due to significant pressure on hospital services at that time. It was disappointing not to be able to celebrate the contributions of staff as planned. The event will be rescheduled and meeting invitations will be sent to all Board members, who are welcome to attend.

5.3. Te Uru Mātai Matengau Leadership

A change proposal to strengthen Tier 3 leadership across Te Uru Mātai Matengau, Cancer Treatment, Screening and Support, was released to affected staff, the Directorate and key stakeholders on 14 July 2021. The consultation period will run for four weeks and a decision is expected to be released in August.

5.4. Te Uru Whakamauora restructure

Following the resignation of the Operations Executive for Te Uru Whakamauora, Healthy Ageing and Rehabilitation, a proposal for change document was released to staff on 28 July 2021. The key changes include transferring some responsibilities to other Directorates. Feedback closes on 11 August 2021.

5.5. Psychology – Child Development Service

In March this year Te Uru Pā Harakeke, Healthy Women, Children and Youth released a change document for the Child Development Service. Following consultation, a decision was made in June to proceed to an outsourced model of service provision for neuropsychological assessments for children with a disability. The new model is expected to improve wait times, patient experience and outcomes. The current DHB provision of this service will end on 1 October 2021 and the tender process has commenced.

5.6. Staff Vaccination Status

Staff have been asked to provide information about their vaccination staff through an online survey. The information gathered will be used to assess the level of vaccine uptake amongst DHB staff as frontline health workers, which is data all DHBs must report to the Ministry of Health. Information will also be used to identify possible barriers for accessing the COVID-19 vaccine and identifying areas where alternative working arrangements may be required to keep staff, patient and visitors safe.

BOARD REPORT

For:

	Approval
	Endorsement
X	Noting

Key questions the Board should consider in reviewing this paper:

- Does the dashboard provide insight on key areas of performance for the Board in an easy-to-understand format?

To	Board
Author	Kelly Isles, Director of Strategy, Planning and Accountability Chiquita Hansen, Interim General Manager, Strategy, Planning and Performance
Endorsed by	Kathryn Cook, Chief Executive
Date	29 July 2021
Subject	**Board KPI Dashboard**

RECOMMENDATION

It is recommended that the Board:

- **note** the areas highlighted in the KPI dashboard and associated commentary.

Strategic Alignment

This report is aligned to the District Health Board's (DHB's) strategy and key enabler, 'Stewardship'.

1. INTRODUCTION

This report provides a regular overview of key performance metrics, applying a Māori health equity perspective to measures (as appropriate) and highlighting where there are significant changes in trends.

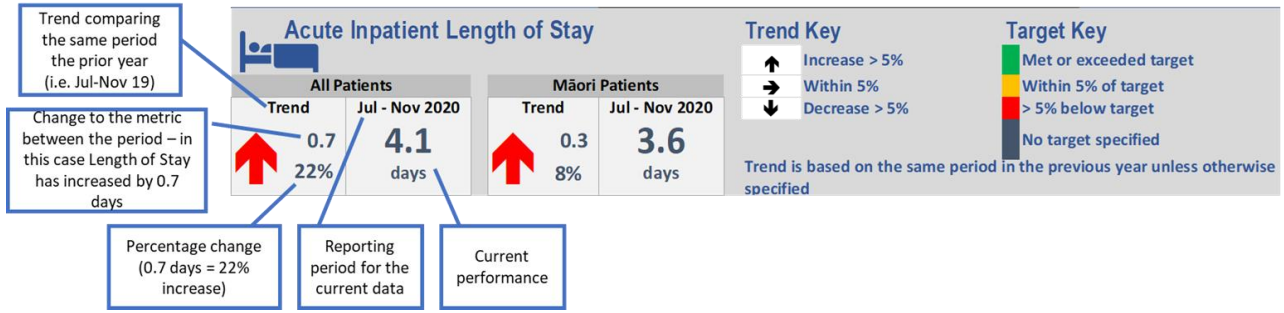
The dashboards in this report present a high-level overview of key indicators. These dashboards cover the period from 1 July 2020 to 30 June 2021.

This report focuses on a one-year comparison, rather than only looking back at the last quarter. This report particularly focuses on areas of non-performance and what steps are being taken to mitigate any risks. Although COVID-19 has had an impact on some areas, overall areas of non-performance have generally remained a challenge. Areas of improvement are identified, such as an increase in non-contact outpatient appointments and a reduction in seclusions for mental health.

Where possible, a graph has been incorporated to provide a comparison between this financial year and the last financial year.

The approach for the KPI dashboard will undergo a review before the next report. The refreshed approach will include a high-level overview of indicators and also provide a closer look at areas of concern, difference or non-performance and explain why this has occurred. This will better inform strategic conversations and planning, as well as reduce risks.

The metrics follow the format outlined below. Green or red trend arrows are used to indicate favourable and unfavourable trends. Where a target exists for a particular metric, the 'Current performance' is colour coded as per the key below.



The underlying data for some metrics will change over time, due to a clinical coding lag. This is particularly relevant for recent data.

2. SERVICE VIEW

3. PERFORMANCE VIEW

BOARD REPORT

Primary & Community Care

Smoking Brief Advice (SBA)
Target: >90%

Non-Māori		Māori	
Trend	Jul 2020 - June 2021	Trend	Jul 2020 - June 2021
18%	85%	16%	81%

Immunisations (at two years)
≥ 95% have completed all age-related immunisations

Non-Māori		Māori	
Trend	Jan - Dec	Change:	Jan - Dec
0.8%	88%	3.9%	89%

Ambulatory Sensitive Hospitalisation (ASH)
Rate per 100,000 (0 - 4 years)

Non-Māori		Māori	
Trend	Jan - Dec	Trend	Jan - Dec
- 1,607 -32%	3,407	- 2,186 -32%	4,660

Older Patients

ED attends: patients aged 75+
Aged 65+ if Māori/Pacifica

Non-Māori		Māori	
Trend	Jul 2020 - June 2021	Trend	Jul 2020 - June 2021
413 6%	7,202 attends	214 19%	1,337 attends

Acute Admissions: patients aged 75+
Aged 65+ if Māori/Pacifica

Non-Māori		Māori	
Trend	Jul 2020 - June 2021	Trend	Jul 2020 - June 2021
- 69 -2%	3,958 admissions	86 14%	691 admissions

Ambulatory Sensitive Hospitalisation (ASH)
Standardised rate per 100,000 (45 - 64 years)

Non-Māori		Māori	
Trend	Jan - Dec	Trend	Jan - Dec
- 584 -15%	3,208	- 598 -9%	6,412

Unplanned Care

Shorter Stays in ED (SSED)
National Target: 95%

Non-Māori		Māori	
Trend	Jul 2020 - June 2021	Trend	Jul 2020 - June 2021
-2%	75%	-2%	78%

Acute Inpatient Length of Stay

Non-Māori		Māori	
Trend	Jul 2020 - June 2021	Trend	Jul 2020 - June 2021
0.4 9%	4.6 days	0.6 21%	3.7 days

Trend Key
- Increase > 5%
- Within 5%
- Decrease > 5%

Target Key
- Met or exceeded target
- Within 5% of target
- > 5% below target
- No target specified

Trend is based on the same period in the previous year unless otherwise specified

Planned Care

Did Not Attend (DNA) Rate

Non-Māori		Māori	
Trend	Jul 2020 - June 2021	Trend	Jul 2020 - June 2021
-0.3%	3.7%	0.1%	11.4%

Case Weighted Discharges (CWDs)

Non-Māori		Māori	
Trend	Jul 2020 - June 2021	Trend	Jul 2020 - June 2021
712 12%	6,596 CWD	206 25%	1039 CWD

ESPI 2 Waiting Times
Target 99.6%

Non-Māori	Māori
30 June 2021	30 June 2021
90%	88%

ESPI 5 Waiting times
Target 99%

Non-Māori	Māori
30 June 2021	30 June 2021
59%	39%

Mental Health

Mental Health Inpatient Length of Stay

Non-Māori		Tangata Whai Ora	
Trend	Jul 2020 - June 2021	Trend	Jul 2020 - June 2021
4.0 41%	13.8 days	7.1 60%	19.0 days

Mental Health Inpatient Seclusions

Non-Māori		Tangata Whai Ora	
Trend	Jul 2020 - June 2021	Trend	Jul 2020 - June 2021
- 12.0 -43%	16 seclusions	- 27.0 -40%	40 seclusions

Mental Health Client DNAs

Non-Māori		Tangata Whai Ora	
Trend	Jul 2020 - June 2021	Trend	Jul 2020 - June 2021
1.1%	6.5% Percentage	2%	8.1% Percentage

4. DETAILED COMMENTARY

4.1. Primary and community

Primary care consultation levels over the last financial year were higher than the previous year which was significantly affected by the impact of COVID-19 lockdowns. Lessons from the lockdown have provided a greater opportunity for people to interact with their general practice teams (GPT) through digital health alternatives, which will continue to develop and grow, reducing barriers to accessing primary care. Daytime consultations for all ethnicities have increased.

After hours consultation levels continue to be higher for both Māori and non-Māori populations. In the last year, several community clinics have held after hours clinics for influenza and COVID-19 vaccinations, which may be affecting overall after hours volumes. Public holidays such as Easter and Anzac Day occurred during lockdown last year which further drove down last year's after hours volumes compared to this year.

Access continues to be a high priority for MidCentral District Health Board (MDHB) and THINK Hauora. The patient experience survey showed that cost is one of the main barriers to accessing primary health care. Localities in the MDHB area advise that easy and timely access to primary, and secondary care, when people need it continues to be their biggest challenge. Continued effort by THINK Hauora to achieve improvement includes additional resource to support GPTs with proactive contact of enrolled patients and ensuring patient details are updated at every contact.

Although the immunisation target of greater than 90 percent has not been achieved this year it is important to note that the Māori population target is now within 10 percent of the Smoking Brief Advice (SBA target, which is a significant increase on the same time last year. The Māori SBA rate is 4 percent lower than the total population SBA rate. Further, an inequity in poor smoking-related health outcomes remains as 19 percent of enrolled Māori are smokers compared to 10 percent of the total enrolled population.

Addressing immunisation rates remains a key national priority. This includes lifting performance in the childhood immunisation programme, completing the Measles, Mumps and Rubella (MMR) catch-up programme and improving influenza immunisation rates. A further priority is the COVID-19 immunisation programme. Childhood immunisation rates in the MDHB district have been static or reducing consistently for the past 18 months, remaining greater than five percent less than the target. Last year, immunisation levels were negatively affected by the lockdown, meaning that many children could not come into general practice when they were due (for example in April and May).

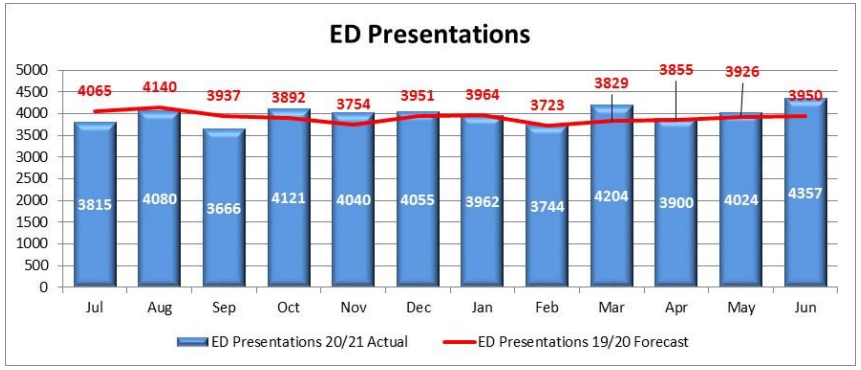
Māori are consistently less likely to have been fully immunised on time across all milestone ages (8 months; two years; five years). Several factors contribute to nationwide and district-wide reductions in immunisation rates to below herd immunity rate. These include mobility of Māori and Pasifika whānau – particularly in the Horowhenua locality; general practice access; COVID-19 anxiety; and rigorous campaigning by underground anti-vax campaigners. The rollout of the COVID-19 vaccination campaign has added additional stress on to the vaccination providers and pressure in the system to quickly build a new vaccinating workforce.

Key approaches to increasing immunisation coverage include ensuring there are sufficient trained vaccinators; an increased focus on supporting those practices who are not achieving targets through targeted communication with all GPTs kānohi ki te kanohi; and exploring mobile options to take immunisation activities into communities. Alongside this, the Outreach Immunisation Service (OIS) continues undertaking routine immunisations and is also holding on-site clinics to catch up overdue tamariki. To reduce barriers to engagement, THINK Hauora has increased resourcing for immunisation clinics in the Horowhenua area and will be utilising clinic space at Raukawa to provide alternative options for whānau for both screening and immunisation.

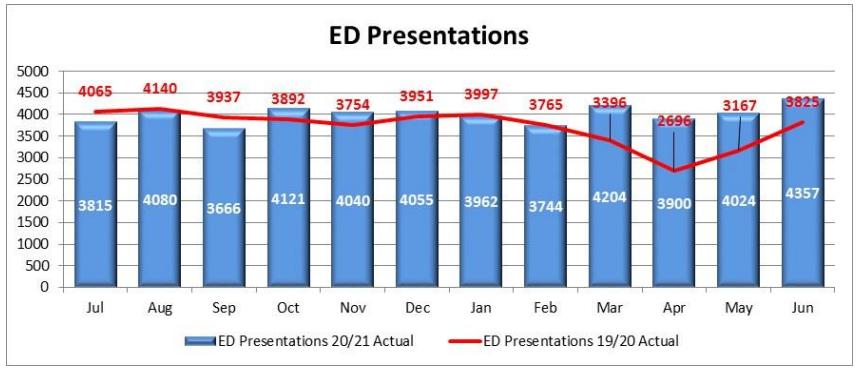
4.2. Unplanned care

Emergency Department (ED) presentations for both non-Māori and Māori increased compared to last year. Whilst the overall increase seems high, monthly presentations are similar to the previous year with the exception of the COVID-19 lockdown and Level Three restrictions which resulted in reduced presentations during March, April, May and June. Based on forecasted ED presentations for 2019/20 (excluding COVID-19) the levels are not dissimilar to this year with the predicted growth.

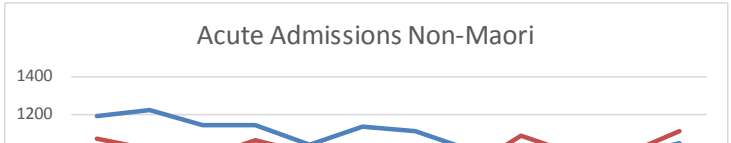
Forecasted

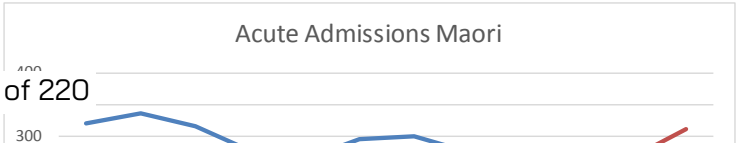


Actual

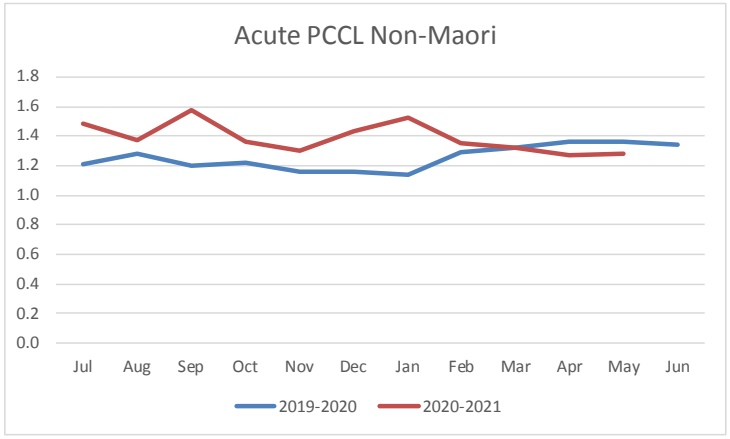


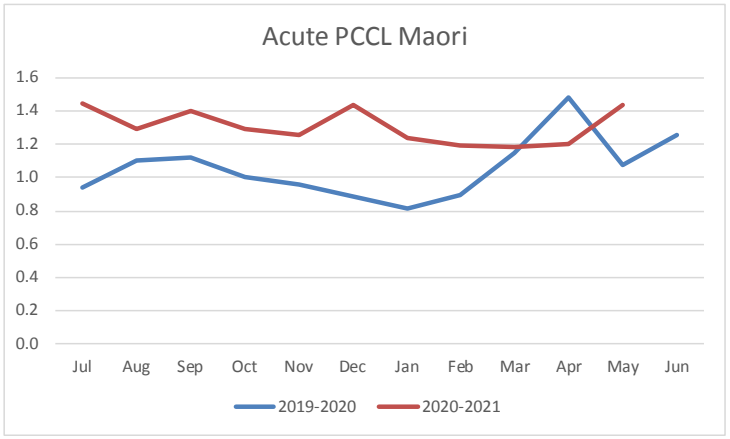
Overall, acute admissions remain lower compared with this time last year. This measure does not reflect the acuity and complexity of patients admitted during the period. There has been a notable increase in acute presentations for cardiovascular and respiratory disorders for both adults and children, including respiratory syncytial virus (RSV) over the last few months. Earlier in the year there was a reduction in the number of children admitted acutely, in part, due to the public health messaging of the importance of hand hygiene and staying home when unwell.





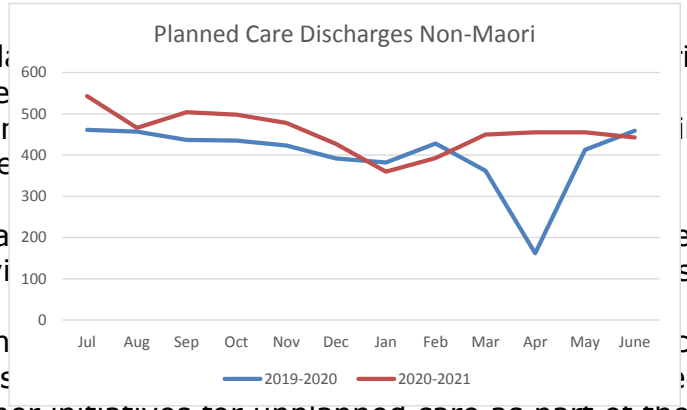
Patient Complexity Clinical Level (PCCL) derived from the coded clinical record for discharge patients shows consistently higher PCCL throughout the year with the increase for Māori more pronounced. These increased PCCLs are driven by increased complexity of patient conditions captured by clinical teams and influenced by a range of factors such as demographics change and the complexity of patients presenting acutely. More complex patients require higher levels of staffing and monitoring. The figures for the last quarter are subject to change as the coding team continue to code the more recently discharged patients.





Achieving the shorter stays in ED health target continues to be a challenge. Overall performance in ED continues to be impacted by high occupancy in inpatient wards (at over 100 percent). This is due to the increased acute inpatient length of stay driven primarily by complex medical patients.

Bed availability to move patients out of ED is a major factor. A new model for acute admissions has been implemented for medical services. This actively encourages patients to be placed into the appropriate inpatient ward. Due to bed availability at times of significant presentations, bed block can hinder this. A process review is being carried out to look at ED flow. Processes for discharge planning has also been identified as a key bottleneck. These issues are inter-related. Facility and workforce challenges also continue to impact on ED.



In the l ic patients presenting with RSV. ED and Paediatrics have been working togethe increased numbers of children presenting with RSV. Specifically, utilising the Childre ing Paediatric staffing resource in ED to fast-track prioritised assessment and treatme

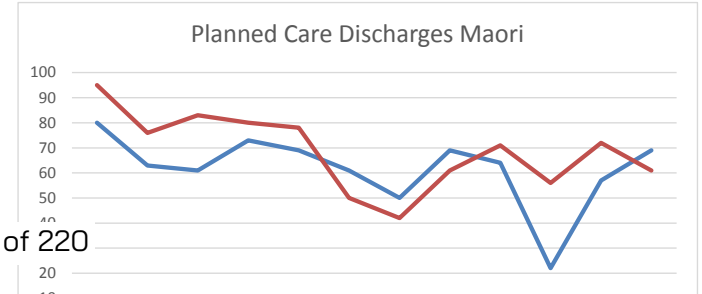
The Tra ed to support patient flow. This has moved from an *ad hoc* basis to daily usage to provi s as staffing resource allows. The TCU is relocated during these times.

There h cross both non-Māori and Māori due to ongoing complexity and comorbidities of patients een in ED has increased as a result. Further information will be provided on this and other initiatives for unplanned care as part of the Health and Disability Advisory Committee (HDAC) Directorate Dashboard.

The increase in Emergency Department (ED) attendances for Māori aged over 65 years, though important, relate to small volumes and small shifts often resulting in large percentage movement. Overall, there has been an increase in acute admissions for Māori and Pasifika aged over 65 years. These are related to medical illnesses, especially relating to the lungs and heart. Health Roundtable data corroborates increased respiratory and cardiac contributions as well as urology, all of which are amenable to early proactive primary care input. The Chronic Obstructive Pulmonary Disease (COPD) hospitalisation rate for Māori aged over 45 years is almost three times that of non-Māori (greater for females). Māori are one and a-half times more likely to be hospitalised for cardiovascular disease, and two times as likely to die from ischemic heart disease. Restricted access to GPTs and cancelled specialist clinics due to COVID-19 could have contributed to more acute admissions.

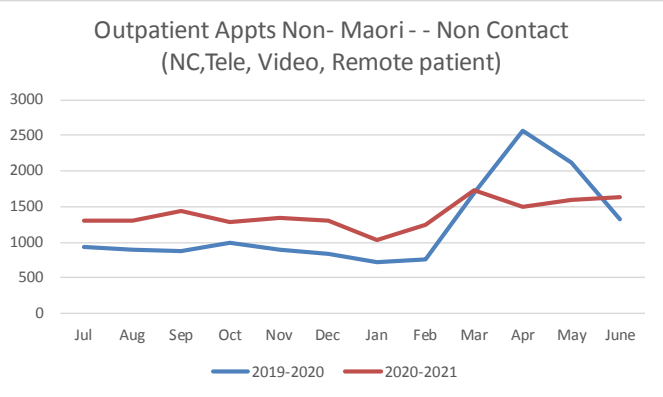
4.3. Planned care

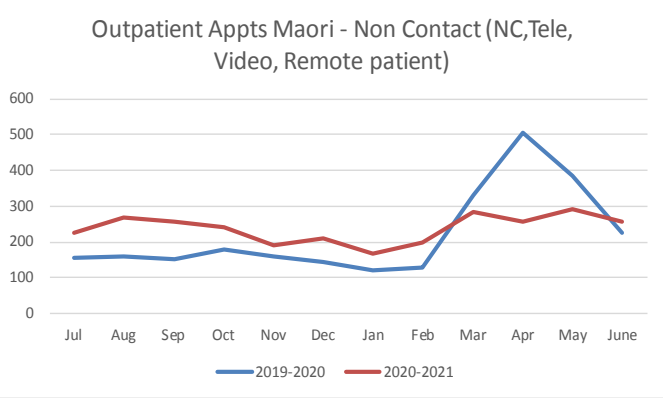
Planned care discharges have increased compared to last year. Notwithstanding COVID-19, this is the result of both the partnership with Crest Hospital and reduced Continuing Medical Education (CME) leave for Senior Medical Officers (SMOs). Earlier in the year, COVID-19 travel restrictions allowed additional surgical lists to be carried out.

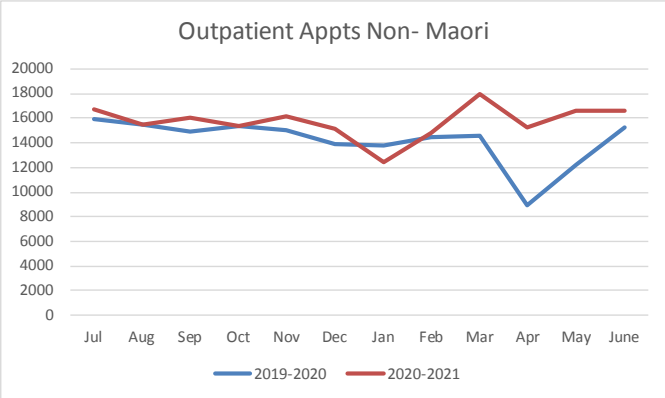


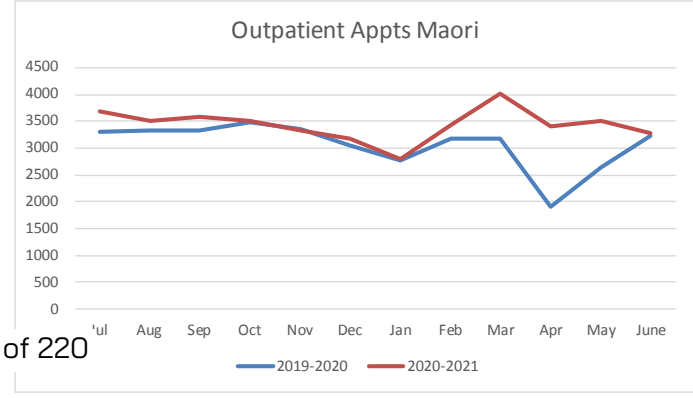
There has been a reduction in ESPI 5 (Elective Services Performance Indicator) compliance based on the number of deferred surgeries in May and June, due to acute demand on inpatient beds and the NZ Nurses Organisation (NZNO) industrial action. While ESPI 5 remains an area of challenge, MidCentral DHB has been working in partnership with Crest Hospital to provide outsourced surgery to further improve performance in this area. The DHB is working with clinicians on prioritising Māori and Pasifika in Planned Care scheduling to ensure there are no unintended consequences. Planned Care waiting lists are produced by ethnicity with regular monitoring to ensure a greater focus on improving Māori timeframes from referral to treatment.

Non-contact (including telehealth) outpatient consultations increased during COVID-19 restrictions. It is important to note they have remained higher than the previous year. This is a result of continuing to implement the lessons from COVID-19 in relation to non-contact outpatient consultations. Overall outpatient consultations have increased this year compared to last year.







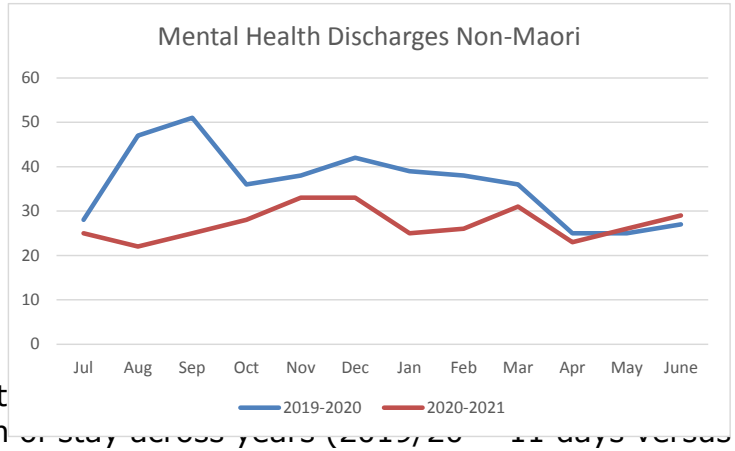


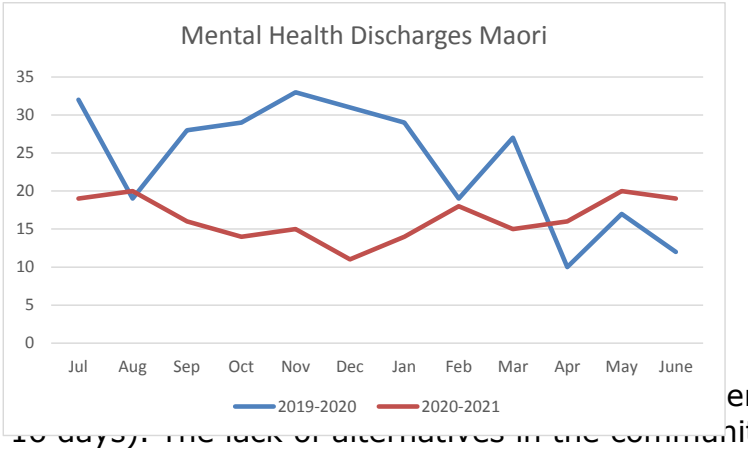
There has been good improvement in ESPI 2 compared to the last quarter. Work will continue to improve this area.

Access to and choice of appointments are stated as the most common reason for Did Not Attends (DNAs). Service users who miss appointments are followed up by the clinical teams and where possible, another appointment is immediately offered. Analysis of the data shows disproportionately high rates of DNAs for Māori when compared to non-Māori. Anecdotal feedback suggests this is related to a lack of cultural options available for Māori when accessing secondary mental health and addiction services. There has been no significant change in the trend for DNAs compared to last year.

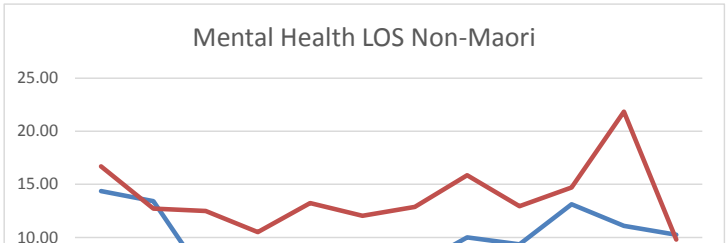
4.4. Mental health

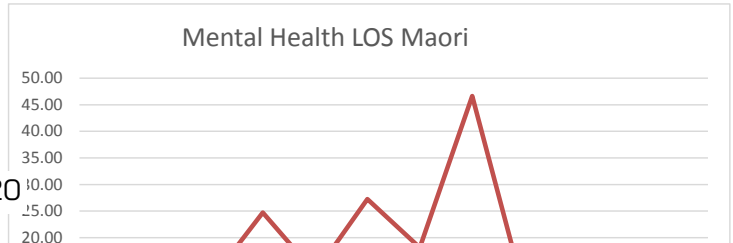
Discharges from inpatient mental health services continue to be significantly down but this is proportional to reduced admissions for this year. These figures relate to a small but very complex number of patients – some individuals have been inpatients for over 100 days. Recent changes to staffing to ensure oversight and facilitation of discharge of patients who are delayed in their discharge due to social issues rather than mental unwellness is making a positive impact.





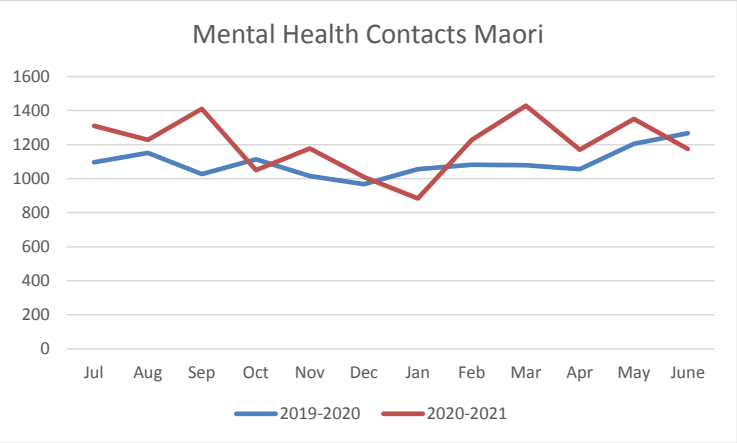
Whilst the defined en change in the length of stay across years (2019/20 = 11 days versus 2020/21 = 10 days). The lack of alternatives in the community also impacts on the inpatient length of stay and occupancy rate in the ward. Some individuals would benefit from an extended care service based in the community, with a focus on rehabilitation and recovery that is not able to be offered within an acute inpatient setting. The proposal to establish a non-acute extended care rehabilitation service was approved at the June 2021 Board meeting. Subject to confirming the service specifications. the service will be implemented within two months.

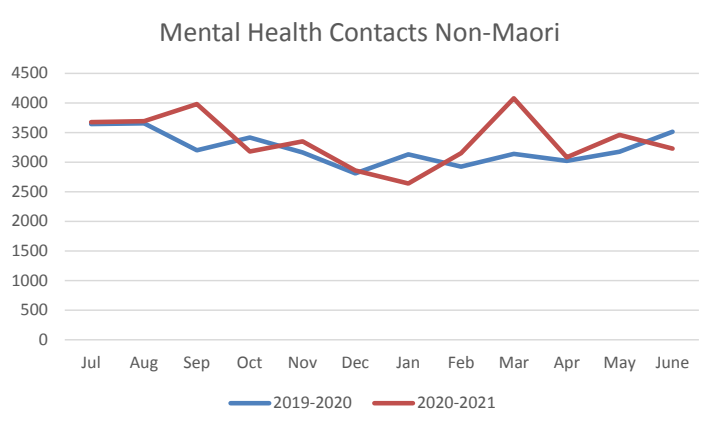




The Health, Quality and Safety Commission's Zero Seclusion project has recently been refreshed. The ward has been focused on its work to reduce and eventually end seclusion, with the number of seclusion rooms being reduced to one. The ward is consistently seeing five or fewer seclusions per month, which is a significant reduction in seclusions (or hours spent in seclusion). The ward continues to strive towards the zero seclusion goal by identifying patterns and addressing these. Further improvements and reductions in seclusion are anticipated over the next 15 months of the project.

There was a significant increase in contacts for Children and Adolescent Family Services and Adult Community Mental Health and Addiction Services in the Horowhenua and Tararua localities in Quarter Three. There has been a 10 percent increase in contact for Māori compared to last year. The new Integrated Model of Care prioritises resources for Māori and localities.





A deep dive analysis was carried out on Did not Attends (DNA) and was included in the April/May 2021 HDAC Directorate report. The analysis confirmed a high level of DNA for Māori. Anecdotal feedback suggested that this higher level of disengagement was due to insufficient options for culturally appropriate care. Improvements in this regard are central to the new Integrated Model of Care for Adult Community Mental Health and Addiction Services that is currently being implemented. Additionally, DNA rates are now included in the monthly KPI report (by Māori and non-Māori) for the Directorate as a key improvement activity.

Data shows tangata whai ora are secluded more and stay longer on the ward than non-Māori patients. Like other health services, this reflects on how unwell the patients are, in comparison, when they are admitted. The new model of care and increasing dedicated kaupapa Māori capacity across the continuum of care seeks to address this inequity.

5. METRIC DEFINITION

The underlying data for some metrics will change over time, due to a clinical coding lag. This is particularly relevant for recent data.

5.1. Service view metric definitions

Metric	Definition	Exclusions
Primary Care Consultations (All)	All primary care consultations that occur in general practice/Integrated Family Health Care (IFHC) settings (including virtual, casual).	COVID-19 testing centres; community and marae-based clinics; primary care consults at THINK Hauora; community based mental health; ACC, Immunisations and Maternity. Excludes Masonic Medical, 1 July 2019 to 13 October 2019 only. Data is missing for Tararua Medical Centre and Village Medical (5300 patients) for 2019 due to these practices refusing to sign data sharing schedules. They are included for 2020.
Primary Care Consultations (after hours)	Subset of consultations that are 6.00pm to 7.59am weekdays, weekends and observed public holidays	As above
People in Aged Residential Care	TBC	
Emergency Department	Number of presentations to the Emergency Department	
Acute Admissions	Number of patients admitted acutely to the DHB (admission type 'AC')	M05 - Emergency Department specialty
Outpatient Appointments	Outpatient appointments attended - based on booking date between parameters	
Planned Care Discharges	Planned care discharges between the reporting period – includes local and inter-district flow (IDF) inflow	
Mental Health Contacts	The number of client-related activities (as per Ministry of Health definition) that involved client participation (DNAs, Family without Client and Service co-ordination activities omitted, written correspondence and SMS messages sent to clients omitted).	
Mental Health Discharges	Mental health ward discharges	

5.2. Performance view metric definitions

Metric	Definition	Exclusions
Smoking Brief Advice (SBA)	Percentage of current smokers (or recent ex-smokers) who have received brief advice to quit smoking or an offer of cessation support in the last 15 months	Patients not enrolled with THINK Hauora; non-coded smoking status and SBA; smokers under 16 years of age
Immunisations (at two years)	As per the Ministry definition used in the non-financial metrics	
Ambulatory Sensitive Hospitalisation (ASH)	As per the Ministry definition used in the non-financial metrics	
Ambulatory Sensitive Hospitalisation (ASH)	As per the Ministry definition used in the non-financial metrics	
Shorter Stays in ED (SSED)	Ministry definition - patients discharged from the emergency department within 6 hours of arrival in the department	
Acute Inpatient Length of Stay	The average length of stay for acutely admitted patients discharged during the reporting period with an admission type of (AC)	
ESPI 2 Waiting Times	As per the Ministry definition used in the non-financial metrics	
Did Not Attend (DNA) Rate	Patients who did not attend their booked outpatient appointment	
ESPI 5 waiting times	As per the Ministry definition used in the non-financial metrics	
Case Weighted Discharges (CWDs)	The case weight derived from eligible coded planned care inpatient discharges	
Mental Health Inpatient Length of Stay	The average length of stay for mental health admitted patients discharged during the reporting period	
Mental Health Inpatient Seclusion rate	The number of seclusion events in the reporting	
Mental Health Client DNAs	The number of unattended booked appointments	
ED attends: patients aged 75+	Presentations at the ED for patients aged over 75 years or Māori and Pacific patients aged over 65 years	
Acute Admissions: patients aged 75+	Acute inpatient admissions for patients aged over 75 years or Māori and Pacific patients aged over 65 years	

BOARD REPORT

For:

X	Approval
	Endorsement
	Noting

To	Board
Author	Darryl Ratana, Deputy Chief Financial Officer
Endorsed by	Finance, Risk and Audit Committee Neil Wanden, General Manager, Finance & Corporate Services
Date	28 July 2021
Subject	**Finance Report – June 2021**

Key questions the Board should consider in reviewing this paper:

- Is the current financial performance and trend in performance sustainable?
- Are the unfunded risks from COVID-19 and Holidays Act compliance manageable in the near term?
- Are the variations from budget sufficiently well explained and reasonable?
- Is there key financial information that you need for governance not included in this report?
- Is the DHB able to trade solvently?

RECOMMENDATION

It is recommended that the Board:

- **note** that this report was endorsed by the Finance, Risk and Audit Committee at their 27 July meeting and no concerns were raised
- **note** that the month operating result for June 2021 is a deficit before one-off items of $0.756m, which is $0.700m favourable to budget
- **note** that the draft year-end result for June 2021 is a deficit before one-off items of $0.357m, which is $4.557m favourable to budget
- **note** that the June 2021 year-end COVID-19 related net costs of $0.100m and unbudgeted Holidays Act related costs of $38.485m have been incurred. Including these one-off costs results in a draft year-end deficit after exceptional items of $38.943m, which is $34.029m adverse to budget
- **note** that the total available cash and equivalents of $36.489m as at 30 June 2021 is sufficient to support liquidity requirements
- **approve** the June financial report.

Strategic Alignment This report is aligned to the DHB's strategy and key enabler 'Stewardship'.

1. REPORT AT A GLANCE

The result for June 2021 is a deficit before one-off items of $0.756m, which is $0.700m favourable to budget.

Favourable to Budget | Close to, or on Budget | Adverse to Budget

Month to Date

Surplus/(Deficit)
($0.8m)
Budget Variance
$0.700m
48.1%

FTEs
2,385
Budget Variance
52
2.1%

Capex
$1.2m
Budget Variance
$4.2m
77.8%

Cash & Deposits Movement
($9.4m)
Budget Variance
($2.8m)
(42.4%)

Month Successes

* Favourable revenue
* Medical Staff close to budget with adverse Outsourced offset by own staff vacancies
* Actual result for June an improvement on that forecasted for the month

Month Challenges

* A number of year-end adjustments accounted for in the month with the most significant being the Holidays Act
* a noticeable drop in FTEs during the month (17 FTE)going against the trend of prior period increases
* Adverse Acute and Elective and Mental Health and Addictions Service (MHAS).
* Capex behind budget but has a positive impact on cash

Year End

Surplus/(Deficit)
($0.4m)
Budget Variance
$4.56m
92.7%

FTEs
2,358
Budget Variance
51
2.1%

Capex
$21.5m
Budget Variance
$32.1m
59.9%

Cash & Deposits
$36.5m
Budget Variance
$28.8m
374.0%

Current Ratio
1.01
Budget Variance
0.20

Year End

This is the draft (unaudited) year end result for the 2020/21 year.

The result is a year end deficit before one off items that is $4.56m favourable to budget. This is prior to absorbing $38.6m of unbudgeted Holidays Act and Covid-19 costs.

Significant challenges include, Acute and Elective and MHAS. HAR (Healthy Ageing) all other Directorates have ended the year favourable to budget.

Employed FTEs are significantly lower than budget, this is partially offset by outsourced staff. Despite this, Personnel costs are adverse largely due to nursing costs and restructuring.

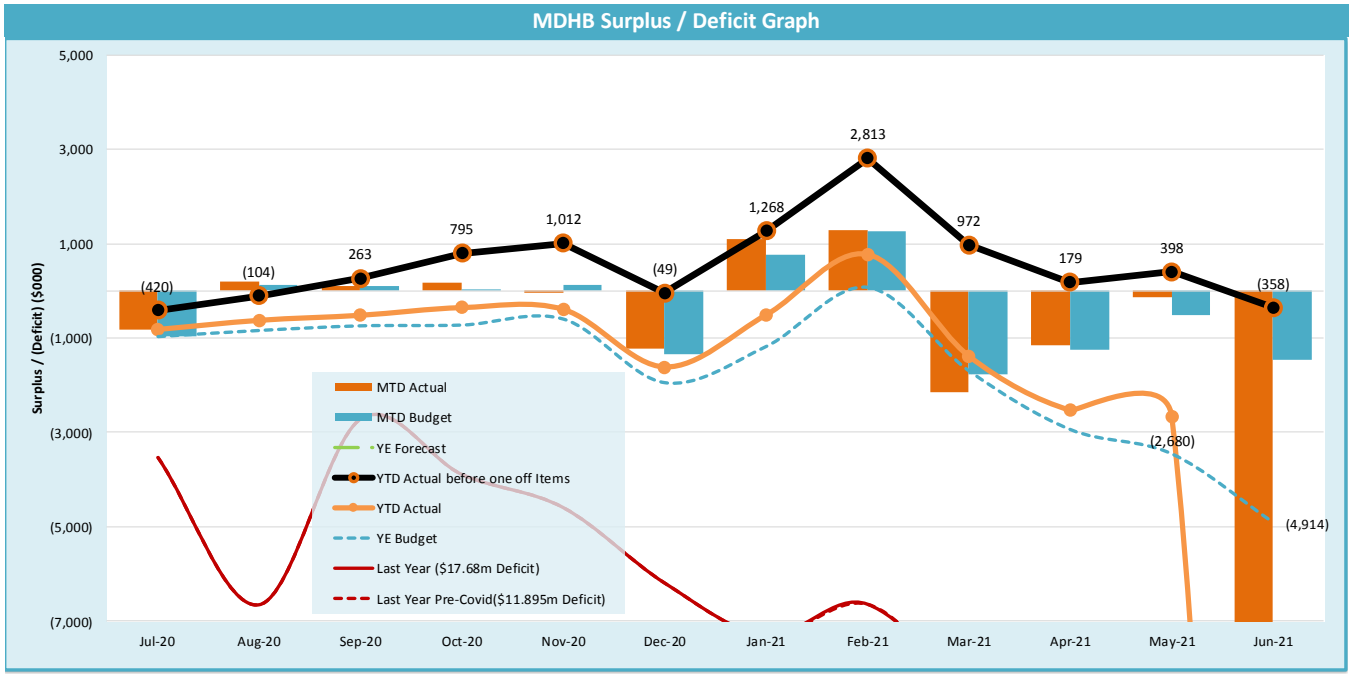
Capital expenditure and cash balances reflects delays in capital projects leading to a positive year end cash position.

Budget Risks

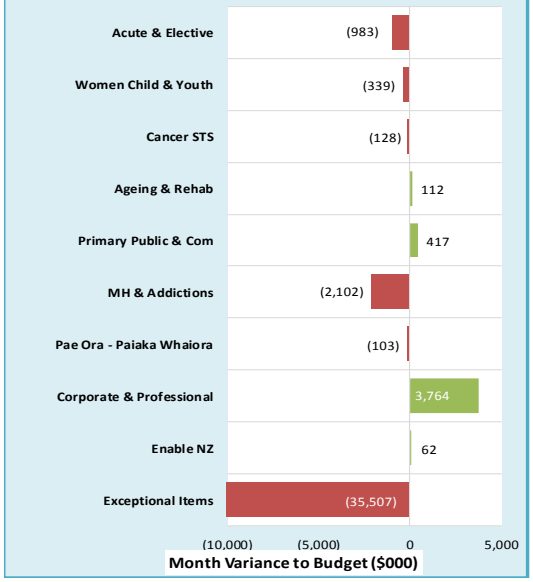
Eight risks were identified in total. The majority of risks either did not eventuate, did not have a significant impact or have been mitigated in some way. The exception was the Holidays Act which is known and will be funded from a cash perspective.

The Current Ratio is a measure of liquidity. It is defined by the Ministry of Health as current assets over current liabilities (excluding employee entitlement provisions). As a comparison, the latest reported average for peer DHBs is 0.6

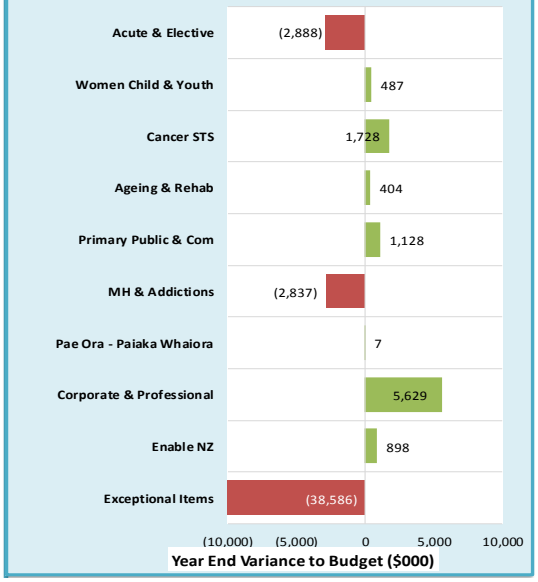
MDHB Surplus / Deficit Graph



Month to Date Variance



Year End Variance



2. FINANCIAL COMMENTARY

Adverse variances are in brackets unless stated otherwise.

2.1 Financial Performance

The MidCentral District Health Board (MDHB) result for June 2021 is a deficit before one-off items of $0.756m, which is $0.700m favourable to budget. Net Revenue for the month is $0.374m favourable to budget and expenditure is $0.638m favourable to budget. The draft year-end result is a deficit of $0.357m, which is $4.557m favourable to budget.

Year-end COVID-19 related net costs of $0.100m and unbudgeted Holidays Act related costs of $38.943m have been incurred. This results in a draft year-end deficit of $38.943m when these one-off costs are included.

The Statement of Financial Performance is shown in the following table. Unbudgeted costs relating to the Holidays Act and COVID-19 are disclosed separately to view the underlying performance.

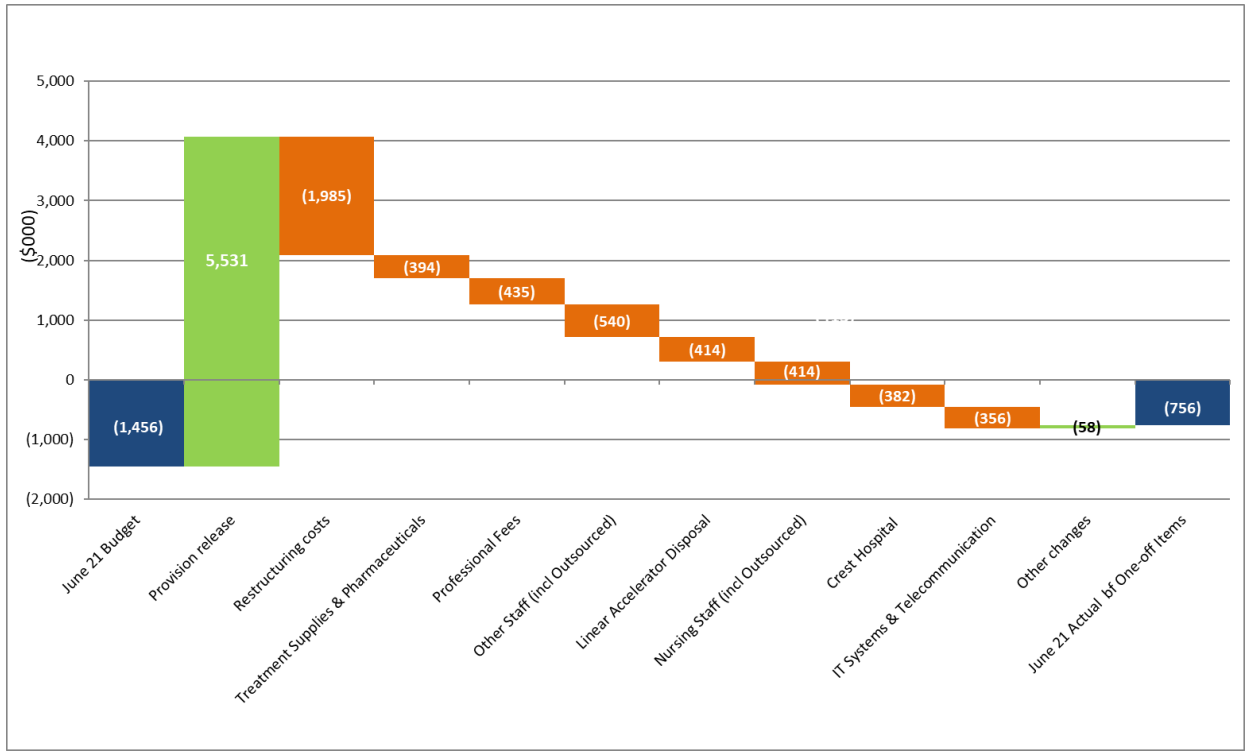
BOARD REPORT

$000	June 2021			Year End		
	Actual	Budget	Variance	Actual	Budget	Variance
Net Revenue	**60,835**	**60,461**	**374**	**736,937**	**724,207**	**12,730**
Expenditure						
Medical	6,924	7,308	384	76,880	82,828	5,948
Nursing	10,417	8,514	(1,903)	107,256	101,337	(5,918)
Allied Health	3,312	3,405	93	36,201	38,251	2,051
Support	155	164	9	1,755	1,848	93
Management / Admin	3,788	3,294	(494)	36,700	36,921	222
Personnel	24,596	22,686	(1,910)	258,791	261,186	2,395
Outsourced Personnel	942	327	(615)	11,298	3,788	(7,510)
Sub -Total Personnel	25,538	23,013	(2,525)	270,089	264,974	(5,115)
Other Outsourced Services	2,751	2,088	(663)	28,225	24,540	(3,685)
Clinical Supplies	6,176	5,117	(1,059)	62,800	59,539	(3,262)
Infrastructure & Non-Clinical	7,492	6,008	(1,483)	72,803	70,889	(1,914)
Provider Payments	19,826	25,820	5,994	305,985	310,890	4,905
Total Operating Expenditure	**61,783**	**62,047**	**264**	**739,902**	**730,831**	**(9,071)**
Operating Surplus/(Deficit)	**(948)**	**(1,585)**	**638**	**(2,965)**	**(6,624)**	**3,659**
Enable Contribution	191	130	62	2,608	1,710	898
Surplus/(Deficit) Before One-Off Items	**(756)**	**(1,456)**	**700**	**(357)**	**(4,914)**	**4,557**
Holidays Act	(35,507)	0	(35,507)	(38,485)	0	(38,485)
Covid-19	0	0	0	(100)	0	(100)
Surplus/(Deficit)	**(36,263)**	**(1,456)**	**(34,808)**	**(38,943)**	**(4,914)**	**(34,029)**

FTE						
Medical	357.8	385.7	27.9	345.5	378.4	32.9
Nursing	1,103.8	1,089.6	(14.2)	1,105.0	1,085.7	(19.3)
Allied Health	432.9	437.0	4.1	418.8	428.8	10.0
Support	30.3	32.4	2.1	29.8	32.3	2.4
Management / Admin	459.8	492.3	32.5	459.3	484.7	25.4
Total FTE	**2,384.6**	**2,437.0**	**52.4**	**2,358.5**	**2,409.8**	**51.4**

Major variances to budget for the month drove the result as indicated in the graph below.

MAJOR VARIANCES TO BUDGET FOR THE MONTH



Revenue variances of significance for the month are as follows:

- Favourable revenue is mainly due to the funding of perfusion materials in Te Uru Mātai Matengau – Cancer Screening, Treatment and Support Services, which has an offsetting expense in pharmaceuticals.
- This was partially offset by both ACC and non-resident revenue that were $0.071m and $0.032m adverse respectively. ACC revenue ended the year $0.320m favourable to budget despite a poor start to the year. Non-resident revenue ended the year $0.094m adverse to budget for the year.

Full-time Equivalent staffing (FTE) for the month are as follows:

- Medical staff are below budget by 28 FTE for the month, with 11 in Te Uru Arotau – Acute and Elective Specialist Services and five in Te Uru Rauhī – Mental Health and Addiction Services. There are 10 long term radiologist vacancies covered by outsourcing. This, combined with Emergency Department FTEs that are above budget by four FTE, impacts Te Uru Arotau. Locums are covering vacancies in Te Uru Rauhī.

- While nursing staff are above budget by 14 FTE for the month, they have dropped by six since last month. Nine are in Te Uru Arotau and 11 in Te Uru Rauhī. These are partially offset by midwifery vacancies in Te Uru Pā Harakeke – Healthy Women, Children and Youth Services and District Nursing vacancies in Te Uru Kiriora – Primary, Public and Community Health Services.

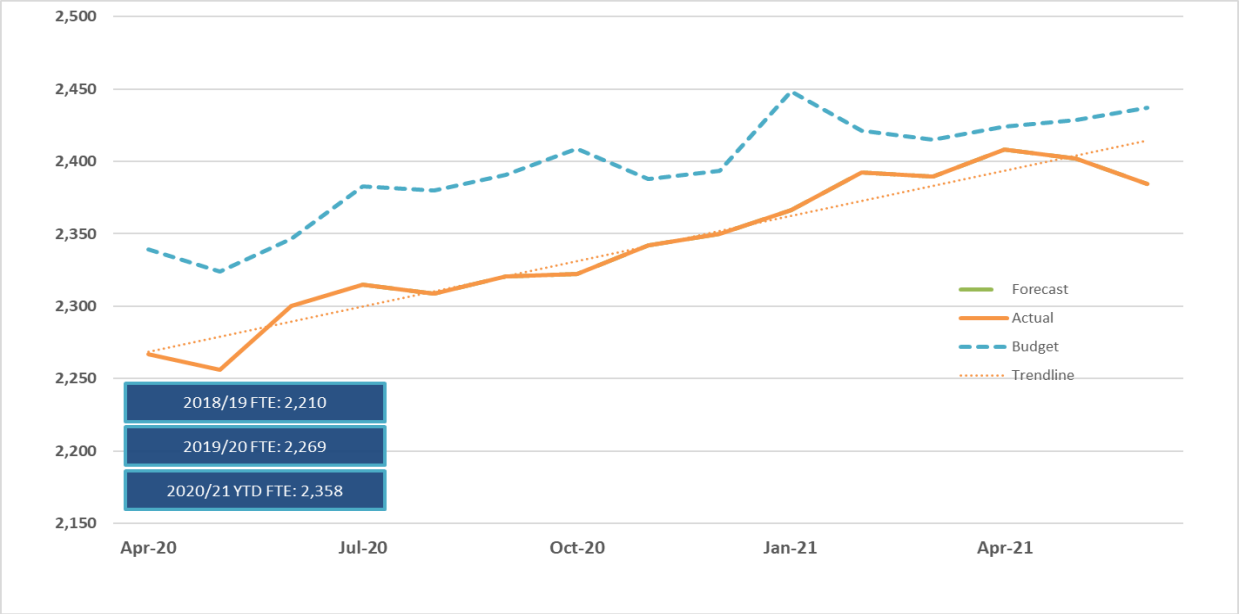
  The filling of nursing vacancies in Te Uru Arotau has outpaced budget projections. In addition, Emergency Department nursing FTEs are ahead of budget by 4 FTE. The Te Uru Rauhī variance is in Ward 21 and STAR 1.

- While Allied Health FTEs are close to budget, Te Uru Arotau is above budget by 12 for the month and reflects a gradual increase across the year. The increases have mainly been in Pharmacy Technicians, Radiology MRTs and Anaesthetic Technicians. These are offset by various vacancies in all other Directorates with Cluster functions. This is evident in Te Uru Kiriora in particular, where vacancies exist in Dental and Public Health.

- Management staff are below budget by 33 FTE for the month in Corporate and Professional Services and Te Uru Rauhī. There was a noticeable nine FTE drop in this staff category in June when compared to the previous month. This was largely in Te Uru Rauhī, Community Mental Health. Within Corporate and Professional Services, there were several small variances across services, with the most significant being in Executive Services and Strategy, Planning and Performance. There was a noticeable nine FTE drop in this category of staff in June when compared to the previous month.

- The table below shows the total FTEs by month for this year. There was a drop of 17 FTE in June when compared to the previous month. This was in administration and nursing roles and considered temporary.

TOTAL EMPLOYED FTES BY MONTH



Personnel variances of significance and points to note are identified below:

- Adverse personnel costs for the month are related to nursing and administration staff restructuring costs that total $1.985m. The majority of this is in Te Uru Rauhī and relates to the impact of the new Mental Health Adult Integrated Model of Care. When these costs are excluded, personnel costs are close to budget for the month.
- Favourable medical staff variances in Te Uru Rauhī of $0.137m are more than offset by adverse locum costs of ($0.284m). While Te Uru Arotau medical staff FTEs are favourable overall, Emergency Department FTEs that are greater than budget is driving an adverse personnel variance for this service.
- The adverse nursing staff variance of $0.300m (before redundancies) feature in all Directorates with Cluster functions except for Te Uru Kiriora – Primary, Public and Community Service, which is favourable by $0.042m. The largest adverse variances are in Te Uru Arotau ($0.113m) and Te Uru Rauhī ($0.261m). This trend has been consistent for the majority of the year.
- Adverse administration staff costs of $0.158m (before redundancies) is driven by several smaller variances across Directorates in addition to staff training programmes related to all job categories but only applied to administration.
- Expenditure on courses, conferences and professional staff fees are on budget for June. Full year spending on training is $1.709m favourable to budget.
- Outsourced personnel were $0.615m adverse to budget. This was mainly due to adverse Te Uru Rauhī locum costs ($0.284m) that are partially offset by favourable employed medical staff (also $0.137m). Te Uru Arotau had adverse costs of $0.129m across all clinical categories. In addition, Digital Services outsourced staff are $0.049m adverse due to the number of recent vacancies and a high level of activity. Outsourced nursing costs, which essentially represent specialling of patients, was adverse to budget for the month by $0.083m. Specialling costs for June were at the average experienced for the year.

Other variances of significance for the month are outlined as follows:

- Other Outsourced Services are adverse to budget due to Outsourced Radiology expenditure ($0.160m) and Crest Hospital for outsourced planned care ($0.382m), both of which impact Te Uru Arotau.
- Adverse Clinical Supplies included the disposal/scrapping of a Linear Accelerator (LINAC)in Te Uru Mātai Matengau – Cancer Screening, Treatment and Support Services in preparation for the replacement LINAC. Adverse treatment supply costs of $0.239m in Te Uru Arotau and pharmaceutical costs of $0.155m in Te Uru Mātai Matengau also impacted Clinical Supplies. Treatment supply costs relate to blood products and pharmaceuticals relate to the use of Pharmaceutical Cancer Treatment (PCTs).
- Provider payments are favourable by $5.994m. In bringing the account to close at year-end, reconstitution of provisions has enabled the release of some funding that offsets other pressures realised.
- Infrastructure and Non-Clinical costs are $1.483m adverse to budget. The key causes of this variance are consultancy fees ($0.435m), IT Systems and Telecommunication ($0.452m) and the cost of Pharmacy stock, which is offset by sales and facility costs. There are several variances for consultancy costs, with the most significant relating to executive support, to support the

financial year end process and technology support for Digital Services. The adverse IT Systems and Telecommunication variance relates to year-end adjustments for items previously considered capital works but now expensed.

2.2 Financial Performance by Service

The statement of 'Net Revenue and Expenditure by Service' is shown in the table below.

$000	June 2021			Year End		
	Actual	Budget	Variance	Forecast	Budget	Variance
Acute & Elective Specialist Services	(14,981)	(13,997)	(983) ✖	(164,570)	(161,682)	(2,888) !
Healthy Women, Children and Youth	(3,258)	(2,919)	(339) ✖	(33,088)	(33,575)	487 ✓
Cancer Screening, Treatment & Support	(3,900)	(3,771)	(128) !	(42,085)	(43,813)	1,728 ✓
Healthy Ageing & Rehabiliation	(9,016)	(9,128)	112 ✓	(108,287)	(108,692)	404 ✓
Primary, Public & Community	(5,699)	(6,115)	417 ✓	(71,363)	(72,492)	1,128 ✓
Mental Health & Addictions	(6,045)	(3,943)	(2,102) ✖	(51,135)	(48,298)	(2,837) ✖
Pae Ora - Paiaka Whaiora	(673)	(570)	(103) ✖	(6,831)	(6,838)	7 ✓
Corporate & Professional Services	42,673	38,908	3,764 ✓	474,995	469,366	5,629 ✓
Enable NZ	141	80	62 ✓	2,008	1,110	898 ✓
Surplus/(Deficit) Before One-Off Items	**(756)**	**(1,456)**	**700** ✓	**(357)**	**(4,914)**	**4,557** ✓
Exceptional Items	(35,507)	0	(35,507) ✖	(38,586)	0	(38,586) ✖
Surplus/(Deficit)	**(36,263)**	**(1,456)**	**(34,808)** ✖	**(38,943)**	**(4,914)**	**(34,029)** ✖

Items of note which impacted service financial performance for the month are outlined below. Further details are provided in Appendix One – Financial Performance by Service.

- Te Uru Arotau – Acute and Elective Specialist Services had an adverse result for the month of $0.983m. This was despite having favourable revenue of $0.195m from inter-district flow (IDF) revenue and unbudgeted revenue of $0.1900m for the Outpatient and Imaging Improvement Action Plan. Planned care revenue was $0.097m adverse and was significantly impacted by the hospital, which experienced significant acute demand pressures which impacted on the ability to undertake targeted levels of planned care.

- Most expenditure items were adverse to budget, with the most noticeable being personnel costs ($0.467m), outsourced services ($0.500m) and clinical supplies ($0.341m). Planned vacancies in nursing and allied health staff that have been filled and FTEs in these two categories are 21 FTE over budget. Outsourced clinical roles, including specialling and locums were also adverse to budget (by $0.129m). Adverse outsourced services were caused by Radiology, Crest Hospital and the cost of health recovery beds. Unfavourable clinical supply variances primarily relate to blood products used in theatre.
- Te Uru Pā Harakeke – Healthy Women, Children and Youth Services was adverse to budget for the month. Planned care activity was impacted due to theatre cancellations caused by a full hospital. Adverse personnel included restructuring costs of $0.083m and adverse clinical supplies and professional fees also contributed to the overall result.
- The favourable month result for Te Uru Mātai Matengau – Cancer Screening, Treatment and Support Services was due to favourable revenue and personnel costs, offset by adverse clinical supplies. Favourable revenue was driven by funding of perfusion materials which has an offsetting expense in pharmaceuticals. Favourable personnel costs are largely due to medical FTEs that are below budget by 4 FTE. Adverse clinical supplies related to the disposal of the Linear Accelerator ($0.414m) which was replaced earlier in the year.
- The favourable variance in Te Uru Whakamauora – Healthy Ageing and Rehabilitation Services results from favourable community provider expenses. This continues an ongoing monthly trend that has occurred since March. Adverse infrastructure expenses are driven by meal and facility costs. Medical and Allied Health staff vacancies persist.
- Te Uru Kiriora – Primary, Public and Community Services was favourable to budget for the month by $0.417m with vacancies in Allied Health and nursing that are 7.2 FTE and 4.1 FTE lower than budget respectively. Allied Health vacancies occur in both Dental and Public Health. Attempts to recruit to positions continue, although there is recognition of national shortages in some occupations such as Dental Therapists.
- Te Uru Rauhī – Mental Health and Addiction Services was adverse to budget by $2.102m for the month, largely due to restructuring costs. This relates to the impact of the new Mental Health Adult Integrated Model of Care which totals $1.909m. Implementation and resource planning for this change is underway. The remainder of the adverse personnel costs are in personnel costs (including outsourced personnel) of $0.233m which is due to nursing costs in Ward 21 and the STAR Ward. A combination of high bed numbers and increased specialling resulted in both a high level of ordinary time and overtime. Ward 21 continues to run over its resourced bed numbers due to demand.
- Provider payments were favourable to budget for the month by $0.135m due to savings from provider contract rationalisation. The year-end saving in provider payments is $0.703m.
- Corporate and Professional Services comprises all executive and enabler functions. The month result was due to favourable revenue partially offset by adverse expenditure in both staffing and community provider payments. Favourable staffing feature in both Strategy, Planning and Performance as well as in the Professional and Executive enablers. Favourable provider payments are due to the revision and release of balance sheet provisions. Favourable revenue was due to additional funding for base electives.

- Exceptional Items contains organisation-wide costs for COVID-19 and Holidays Act. Both of these are unbudgeted. The budget assumption is that the Ministry of Health (the Ministry) will fund any reasonable and actual COVID-19 expenditure. In addition, the Ministry required all DHBs to remove Holidays Act costs from their 2020/21 budgets. Refer to sections 2.3 and 2.4 below.

- The June 2021 result for Enable New Zealand is due to favourable income from trading activities and procurement rebates. Trading activities include direct sales, equipment hire, equipment refurbishment and freighting of complex equipment.

A Statement of Net Revenue and Expenditure by Division is shown in the table below.

$000	June 2021			Year End		
	Actual	Budget	Variance	Forecast	Budget	Variance
Funding Division	385	1,788	(1,403) ✗	23,576	22,522	1,054 ✓
MidCentral Provider	(36,051)	(3,324)	(32,727) ✗	(62,824)	(28,546)	(34,277) ✗
Enable NZ	141	80	62 ✓	2,008	1,110	898 ✓
Governance	(739)	(0)	(739) ✗	(1,703)	0	(1,703) ✗
Surplus/(Deficit)	**(36,263)**	**(1,456)**	**(34,808)** ✗	**(38,943)**	**(4,914)**	**(34,029)** ✗

2.3 Holidays Act

Year-end expenditure on the Holidays Act totals $35.507m. This is made up of expenditure on the compliance project of $1.829m and increases to the provision of $33.678m. The adjustment to reflect the reassessment of the liability estimate based on the review undertaken by Ernst Young was actioned in June. The year-end balance sheet provision for staff remediation for Holidays Act breaches since June 2010 is currently forecast to be $47.0m. The overall quantum is consistent with findings from other DHBs in that the annual cost is *circa* between two and three percent of total payroll costs.

It is important to note that the Ministry separates Holidays Act issues from the measurement of DHB performance and that DHBs were explicitly requested not to budget for this cost in the 2020/21 year. The Holidays Act is a national issue faced by all DHBs, and the expectation is that this will require separate funding to remediate. The Government has signalled that it will provide this funding once all DHBs are in a position to rectify. This is most likely to come as deficit support.

2.4 COVID-19

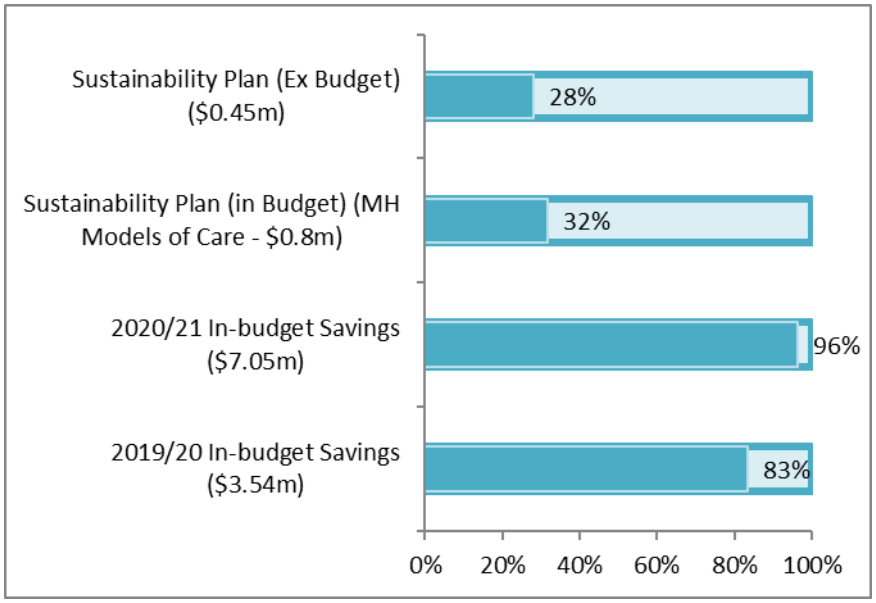
While net expenditure during June was minimal, this reflects $1.136m of immunisation funding offset by expenditure of the same quantum. Funding is for immunisation staff and facility costs to undertake vaccinations at the new city centre location. Staffing totalled 48 FTE for the month, a significant increase from last month due to the increase in immunisation activity. The year-end unbudgeted net expenditure totals $0.100m and is related to fit testing of N95 masks.

The Ministry has provided advice on the funding model for the immunisation programme, which is in line with MDHB expectations.

2.5 Sustainability and Savings Plan

The table below shows the actual achievement compared to the year-end target. Overall 85 percent of the savings target has been achieved. While these specific saving targets were not fully achieved, the DHB's overall performance is close to budget when one-off items are excluded.

SUSTAINABILITY AND SAVINGS PLAN PROGRESS TO DATE



2.6 Budget Risks

A number of potential risks were identified at the beginning of the financial year. If realised, these had the potential to significantly affect MDHB's ability to achieve budget. The majority of risks either did not eventuate, did not have a significant impact or have been mitigated in some way. The exception was the Holidays Act. While this did impact on the overall financial performance for 2020/21, it has been viewed as tolerable because cash costs will be funded when these materialise.

A summary of these risks are outlined in the following table.

Potential Budget Risk	Current Status
Achieving Sustainability and Saving Plan Objectives	
While the financial impacts of some sustainability initiatives are not specifically budgeted, these must be achieved to help absorb any unplanned shocks to the DHB.	Overall 85 percent of the overall savings target has been achieved. While these specific saving targets were not fully achieved, the DHBs overall performance is close to budget when one-off items are excluded.
Ongoing Impacts of COVID-19	
The impact of a second outbreak would be disruptive to the DHB and its budget. Staff annual leave will need to be carefully managed from both a staff wellbeing and financial perspective.	There have been no significant unfunded COVID-19 costs during the year. MoH is funding the immunisation programme in line with MDHB cost expectations.
Timing of staff recruitment	
The budget reflects average vacancy levels based on the assumption that not all positions will be able to be recruited. It also includes phasing adjustments on the basis that the need to fill positions will occur gradually throughout the year.	The year-end FTE variance is below budget by 15 FTE when all personnel costs (outsourced and employed) are considered. This gap has been present or year albeit reducing overtime. Note that nursing FTEs have been above budget for most of the year and are currently 20 FTE above budget. The outcome of CCDM reviews suggests additional nursing resource is required in several wards. The impact of this will impact on 2021/22.
Future MECA settlements	
The budget assumption is for a modest 1.5 percent increase in wage settlements based on the Government's expectation of restraint in the public sector given COVID-19 and its impact on the economy.	Overall average salary costs remained within budget expectations during the year.

Achieving Planned Care targets	
The Ministry proposed targets require an increase in output from MidCentral DHB to achieve similar revenue levels as in 2019/20.	Planned Care activity has been relatively high this year, albeit additional costs have been incurred through subcontracting.
Hospital Capacity	
Hospital bed capacity was increased during 2019/20 to accommodate growing demand. For 2020/21, several projects will commence being the SPIRE and EDOA/MAPU PODS projects. While the long-term benefit increases in future capacity, the short-term impact will lead to some disruption.	High bed occupancy has been experienced throughout the year to date. Disruption from construction projects were minor this year. Both SPIRE and EDOA/MAPU will have a greater impact in the next year. Mitigation plans are in place for this.
Holidays Act	
Work to further define the financial impact is ongoing and will be revised as the project comes to a better understanding of the liability. The risk is that the liability will move because of that work, thereby affecting the planned deficit.	While this has impacted the overall result, Holidays Act costs will be funded centrally by the Ministry. For this reason, the risk rating has been seen as tolerable.
WebPAS SaaS	
A proposal to move from the current regional instance of WebPAS to a Software as a Service (SaaS) offering is being developed for consideration. Any move away from the current model June trigger the need to consider impairment.	While work continues on the business case, the outcome of any proposal is uncertain.

2.7 Financial Position

The main budget variances in the Balance Sheet at 30 June 2021 relate to the revaluation of land and buildings, which resulted in higher than budgeted non-current assets and equity; and the increase to the Holidays Act compliance provision which resulted in higher than budgeted current liabilities. Timing differences in contractor payments and income received in advance, as well as the timing of capital expenditure being later than anticipated, has resulted in higher than budgeted cash on hand and deposits in current assets.

As at 30 June 2021 the total available cash and deposit balances were $36.489m. Significant capital expenditure was budgeted for the 2020/21 year, and the timing of this expenditure has run later than planned.

$000	Jun-20	Jun-21		
	Actual	Actual	Budget	Variance
TOTAL ASSETS				
Non Current Assets	213,669	293,387	243,112	50,275
Current Assets	58,699	68,877	39,689	29,188
Total Assets	**272,368**	**362,264**	**282,801**	**79,463**
TOTAL EQUITY AND LIABILITIES				
Equity	158,340	207,943	173,429	(34,514)
Non Current Liabilities	7,713	6,278	7,626	1,348
Current Liabilities	106,315	148,043	101,747	(46,296)
Total Equity and Liabilities	**272,368**	**362,264**	**282,801**	**(79,463)**

2.8 Cash Flows

Overall cash flows reflect a favourable variance to budget of $28.823m as at 30 June 2021. Operating cash flows are favourable due to the net impact of working capital movements. Investing cash flows are favourable due to the timing of capital expenditure being later than budgeted. Financing activities are unfavourable due to equity injections for the SPIRE and mental health projects being later than budgeted.

$000	Jun-20	Jun-21			
	Actual	Actual	Budget	Variance	
Net Cash Flow from Operating Activities	15,541	24,384	14,548	9,836	✓
Net Cash Flows from Investing Activities	(19,204)	(20,859)	(53,535)	32,676	✓
Net Cash Flows from Financing Activities	1,632	5,980	19,669	(13,689)	✗
Net increase / (decrease) in cash	**(2,031)**	**9,505**	**(19,318)**	**28,823**	✓
Cash at beginning of year	29,015	26,984	26,984	-	✓
Closing cash	**26,984**	**36,489**	**7,666**	**28,823**	✓

2.9 Cash, Investments and Debt

Cash and Investments

Trust and Special Funds are held in a separate BNZ account. These fall outside the shared banking arrangement with the BNZ that NZ Health Partnerships Limited sweeps daily. Surplus liquidity from the Enable New Zealand operating account is channelled through the main DHB accounts to obtain those benefits.

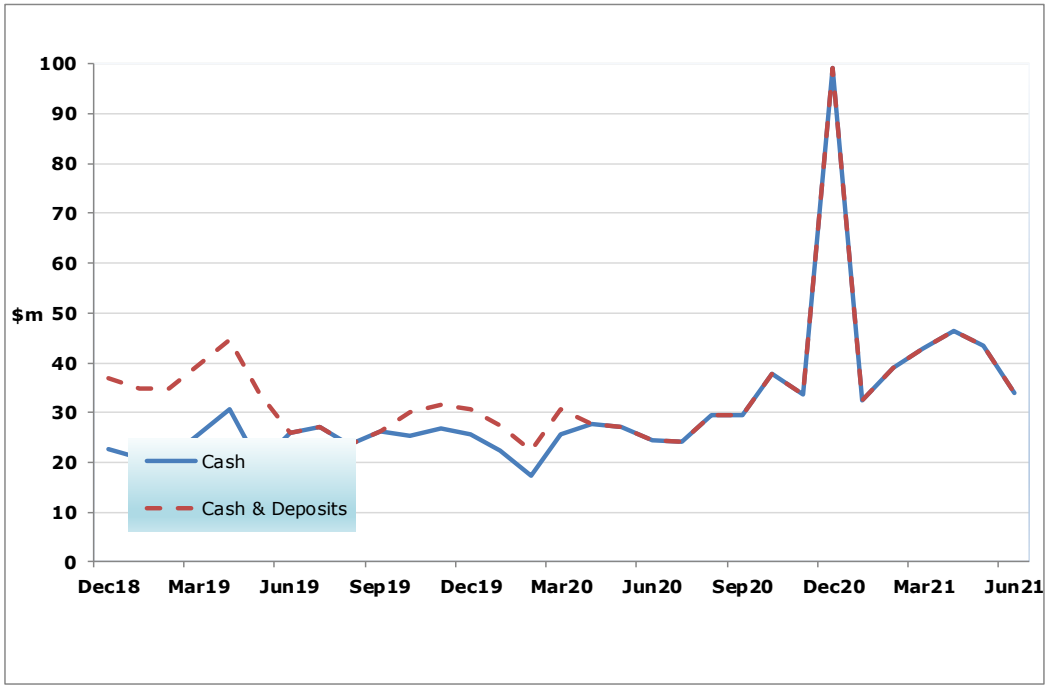
Jun-21	Rate	Value $000
NZHP Sweep Balance	0.67%	33,330
Cash in Hand and at Bank		2
Trust Accounts		2,462
Enable New Zealand		695
Cash Balances		36,489
Total Cash Balance		**36,489**

The cash reconciliation table below shows how cash has moved during the month.

Cash Reconciliation	Jun-21 $000	Year to date $000
Cash at May 2021	45,893	26,984
Surplus / (Deficit) for mth	(36,263)	(38,943)
Depreciation / Amortisation	2,006	23,259
Sale of fixed assets	420	450
Working capital movement	25,905	40,132
Share of associate net surplus/deficit	-	(126)
Capital expenditure	(794)	(21,075)
Loan/finance lease repayments	(17)	(268)
Trusts movement	(28)	(241)
Equity repayment	(633)	(633)
Equity injections - capital	-	6,950
Cash Balance at month end	**36,489**	**36,489**

The chart below indicates the DHB's cash balance, excluding investment and Trust Accounts. The spike in the December cash balance reflects the early payment of January revenue by the Ministry due to the timing of the Christmas holiday period.

CASH BALANCES



The DHB sector as a whole is experiencing liquidity pressure due to the continuation of operating deficits. New Zealand Health Partnerships, on behalf of all DHBs, has been in ongoing discussion with the Ministry and Treasury on ways to resolve this and the need for urgent deficit support equity injections to those DHBs who are insolvent. That resulted in an equity injection to the sector last October to accommodate payment timing. These pressures have not affected MDHB operations to date. However, a resolution is necessary to enable the collective treasury management and optimisation to remain viable.

The Ministry has provided reassurance to the sector on the liquidity impacts of COVID-19. Despite this, COVID-19 will influence the ability to fund other initiatives in the sector in the near term.

The Ministry has also give reassurances that the cost of Holidays Act remediation will be funded separately at the time payments to remediate those employees impacted (past and present) are required to be made.

Net MDHB liquidity continues to be sufficient in the near term with steady levels. However, continuing operating deficits and planned capital investments are reducing the overall liquidity.

The Treasury and the Ministry are providing a funding allocation of $30m towards the $35m budget for the Mental Health Unit replacement and $27.5m for an expanded perioperative suite (SPIRE programme). The increased funding commenced this financial year with the bulk of the drawdowns as major construction occurs over the next two years.

Treasury Policy and Ratios

There are currently no arrangements that necessitate monitoring against Treasury Policy parameters.

Debt and Leases

Debt previously held with the Energy and Efficiency Conservation Authority (EECA) has now been fully repaid. EECA has a Crown Efficiency Loan Scheme for assisting Government-funded organisations in taking measures to reduce their energy expenditure.

The MRI finance lease is held with MCL Capital which is a New Zealand owned and operated company offering leasing solutions to New Zealand public sector organisations.

Finance Leases	Start Date	Maturity	$'000	Equipment
MCL Capital	Jun-19	June-26	1,120	MRI Scanner

The finance lease allows the DHB to spread the cost of an asset over the term of the lease and preserves capital, minimises the draw on cash reserves and provides budget certainty with ownership at the lease expiry.

2.10 Statement of Capital Expenditure

Capital expenditure is below the overall budget, a trend that has continued from last year. Expenditure in June totalled $1.212m largely due to the SPIRE project. Year-end, expenditure on capital is $21.496m. Note that year-end depreciation is $22.752m against a budget of $23.241m.

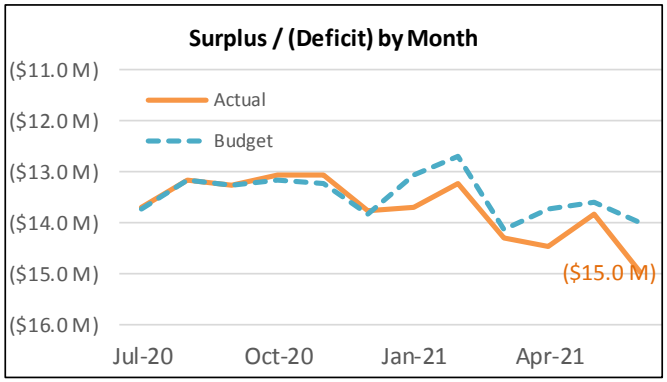
Further detail is provided in Appendix Two – Capital Expenditure.

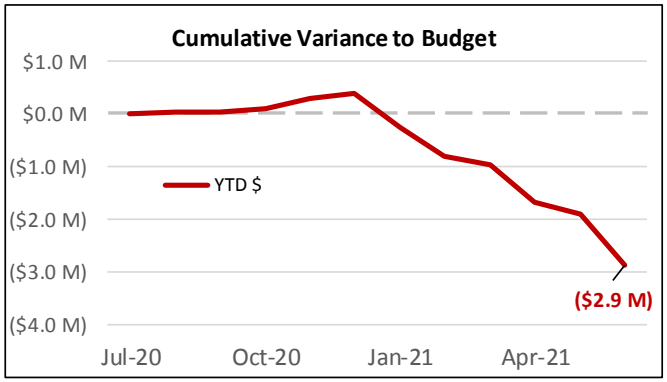
APPENDIX ONE – FINANCIAL PERFORMANCE BY SERVICE

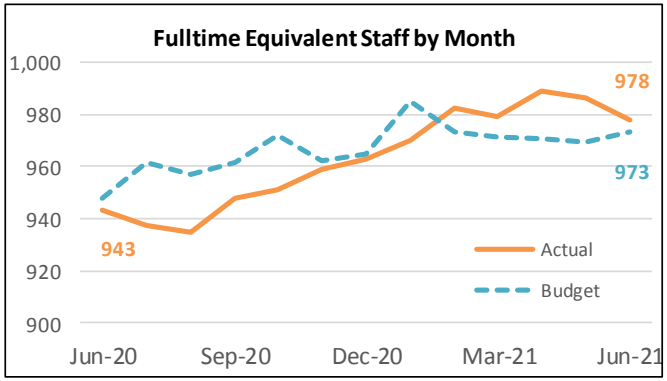
Te Uru Arotau – Acute and Elective Specialist Services

$000	June 2021 Actual	June 2021 Variance to Budget	Year End Forecast	Year End Variance to Budget
Net Revenue	**1,957**	**593**	**25,640**	**9,576**
Expenditure				
Personnel	10,067	(338)	113,299	(1,558)
Outsourced Personnel	206	(129)	3,025	(2,132)
Sub -Total Personnel	10,273	(467)	116,324	(3,691)
Other Outsourced Services	1,580	(500)	15,690	(3,004)
Clinical Supplies	3,404	(341)	40,015	(4,410)
Infrastructure & Non-Clinical	788	(287)	7,304	(1,421)
Total Operating Expenditure	**16,046**	**(1,595)**	**179,334**	**(12,526)**
Provider Payments	9	19	265	79
Corporate Services	883	0	10,611	(18)
Surplus/(Deficit)	**(14,981)**	**(983)**	**(164,570)**	**(2,888)**

FTE				
Medical	227.8	10.8	220.2	13.7
Nursing	479.7	(9.4)	480.6	(9.0)
Allied Health	135.0	(12.3)	127.7	(5.9)
Support	17.1	2.0	16.7	2.3
Management / Admin	118.4	4.2	119.5	2.8
Total FTE	**977.9**	**(4.7)**	**964.7**	**3.7**

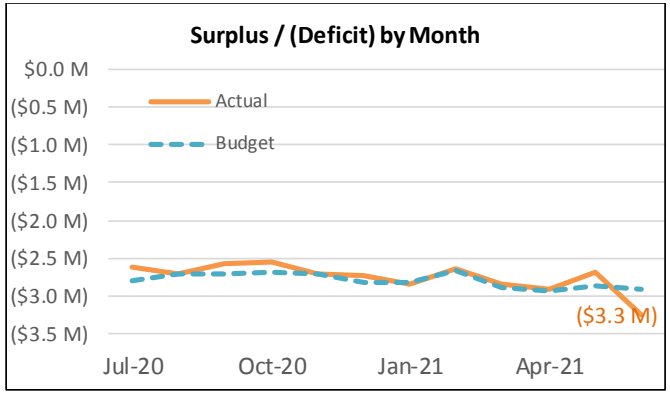


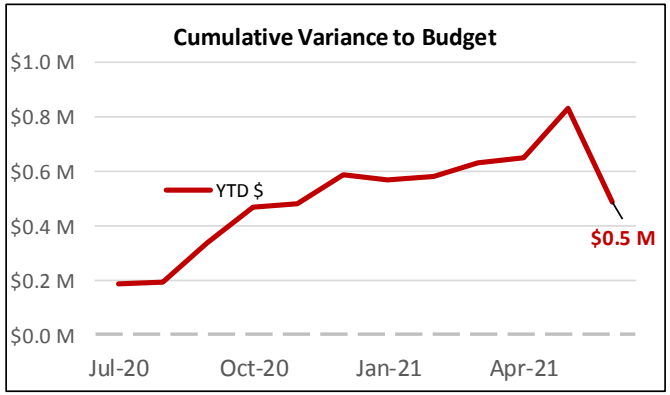




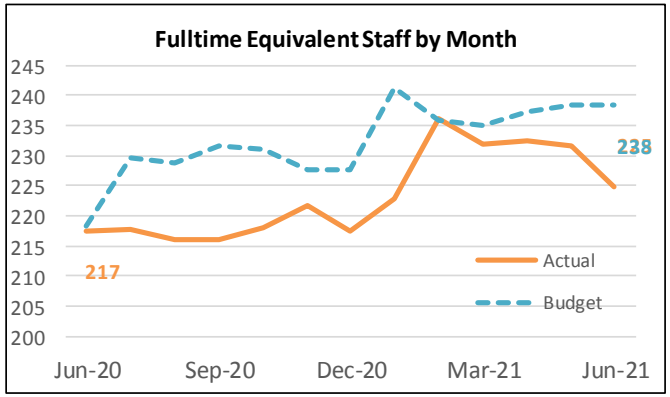
Te Uru Pā Harakeke – Healthy Women, Children and Youth Services

$000	June 2021 Actual	June 2021 Variance to Budget	Year End Forecast	Year End Variance to Budget
Net Revenue	**394**	**(63)**	**5,449**	**(12)**
Expenditure				
Personnel	2,491	(113)	26,194	1,032
Outsourced Personnel	59	(38)	673	(430)
Sub -Total Personnel	2,550	(151)	26,867	601
Other Outsourced Services	74	(3)	1,002	(163)
Clinical Supplies	372	(93)	3,457	(200)
Infrastructure & Non-Clinical	258	(99)	1,742	122
Total Operating Expenditure	**3,254**	**(346)**	**33,068**	**361**
Provider Payments	384	70	5,307	139
Corporate Services	14	0	162	0
Surplus/(Deficit)	**(3,258)**	**(339)**	**(33,088)**	**487**





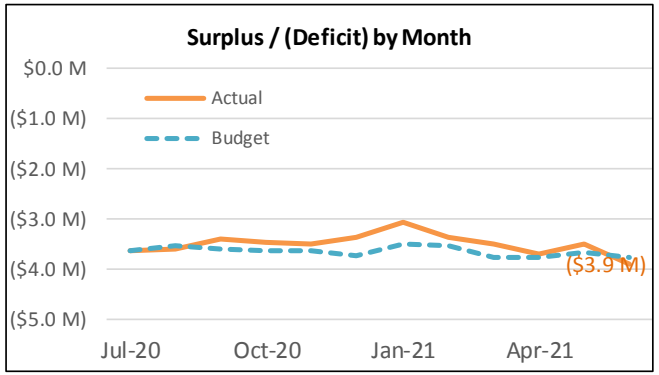
FTE				
Medical	43.3	1.9	42.1	2.6
Nursing	113.3	10.7	146.6	(31.5)
Midwives	35.0	(3.5)	35.5	1.4
Allied Health	14.0	2.8	14.8	1.1
Support	0.0	0.0	0.0	0.0
Management / Admin	19.3	1.6	20.4	0.6
Total FTE	**224.9**	**13.5**	**259.4**	**(25.9)**

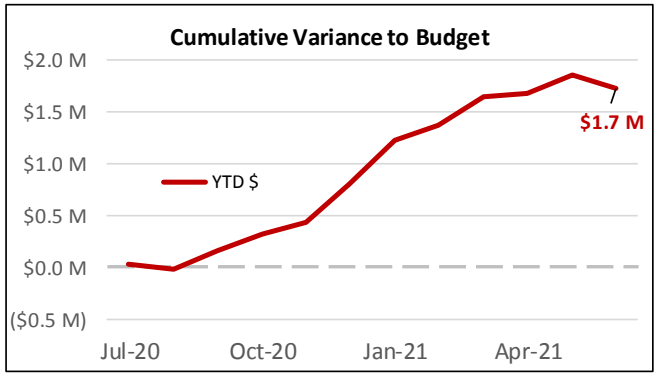


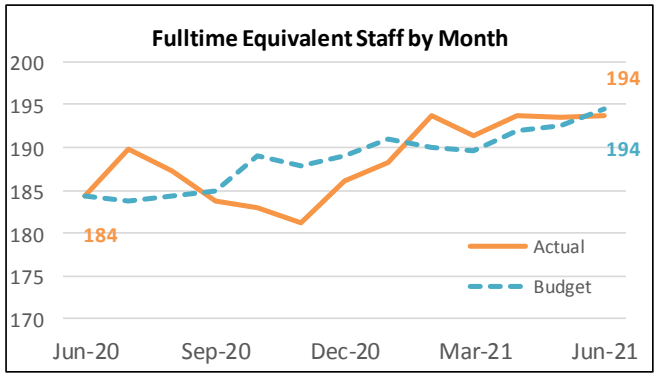
Te Uru Mātai Matengau – Cancer Screening, Treatment and Support Services

$000	June 2021 Actual	June 2021 Variance to Budget	Year End Forecast	Year End Variance to Budget
Net Revenue	**1,193**	**269**	**11,598**	**1,165**
Expenditure				
Personnel	1,875	186	22,232	1,054
Outsourced Personnel	13	(9)	91	(51)
Sub -Total Personnel	1,888	177	22,324	1,003
Other Outsourced Services	630	(29)	7,123	(71)
Clinical Supplies	1,853	(563)	15,215	(213)
Infrastructure & Non-Clinical	115	12	1,722	(212)
Total Operating Expenditure	**4,486**	**(404)**	**46,383**	**508**
Provider Payments	388	6	4,671	56
Corporate Services	219	0	2,629	0
Surplus/(Deficit)	**(3,900)**	**(128)**	**(42,085)**	**1,728**

FTE				
Medical	37.9	3.7	38.9	1.4
Nursing	57.6	(1.0)	56.1	(1.1)
Allied Health	65.9	0.3	63.4	0.9
Support	0.0	0.0	0.0	0.0
Management / Admin	32.2	(2.2)	30.3	(1.0)
Total FTE	**193.6**	**0.8**	**188.8**	**0.2**



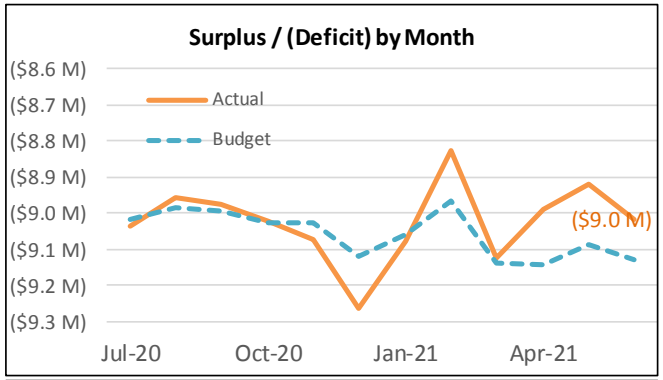


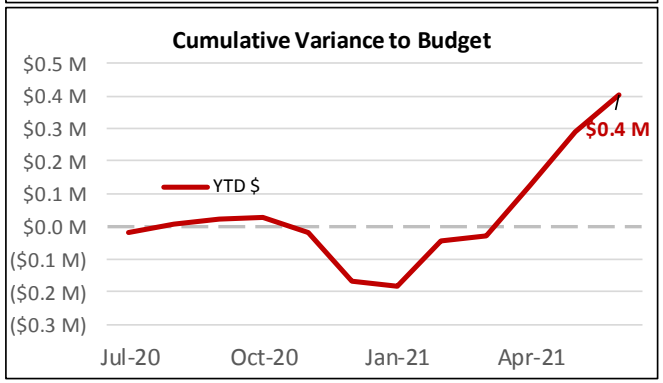


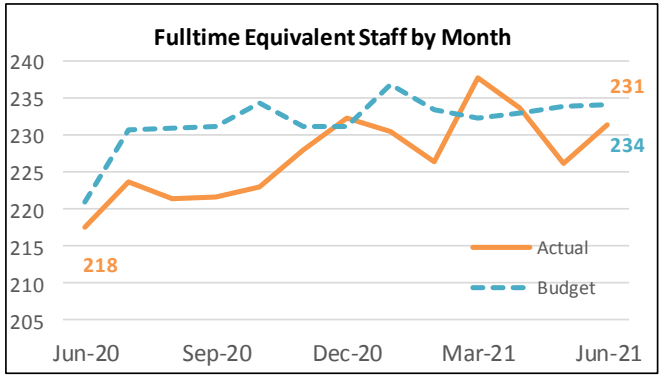
Te Uru Whakamauora – Healthy Ageing and Rehabilitation Services

$000	June 2021 Actual	June 2021 Variance to Budget	Year End Forecast	Year End Variance to Budget
Net Revenue	**411**	**(32)**	**5,302**	**188**
Expenditure				
Personnel	1,858	8	21,100	394
Outsourced Personnel	76	(37)	983	(530)
Sub -Total Personnel	1,934	(28)	22,083	(136)
Other Outsourced Services	60	(11)	682	(100)
Clinical Supplies	157	(7)	1,972	(231)
Infrastructure & Non-Clinical	151	(41)	1,538	(255)
Total Operating Expenditure	**2,303**	**(87)**	**26,275**	**(722)**
Provider Payments	7,035	231	86,248	939
Corporate Services	89	0	1,066	0
Surplus/(Deficit)	**(9,016)**	**112**	**(108,287)**	**404**

FTE				
Medical	14.7	3.8	14.9	3.1
Nursing	109.3	(5.0)	109.0	(4.2)
Allied Health	91.3	5.2	89.9	5.3
Support	0.0	0.0	0.0	0.0
Management / Admin	16.2	(1.3)	14.3	0.6
Total FTE	**231.5**	**2.6**	**228.0**	**4.8**



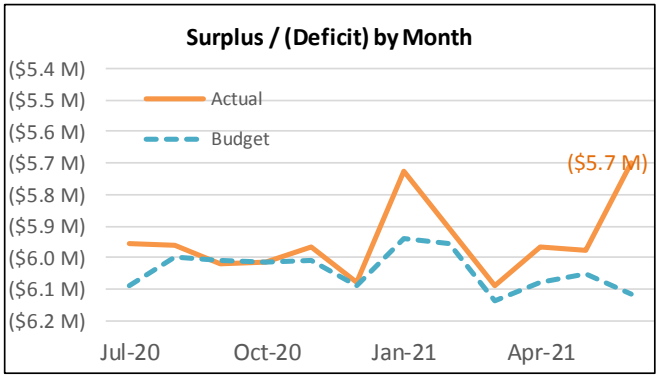


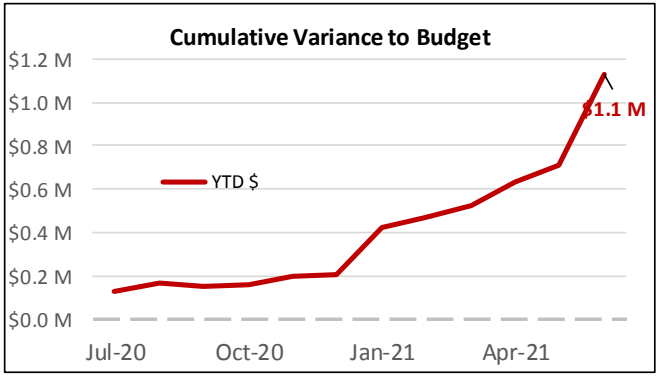


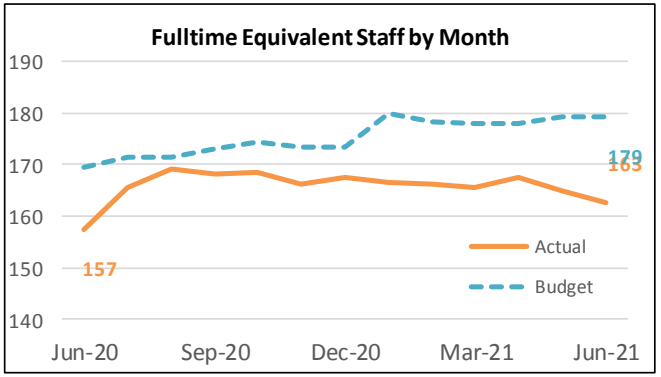
Te Uru Kiriora – Primary, Public and Community Services

$000	June 2021 Actual	June 2021 Variance to Budget	Year End Forecast	Year End Variance to Budget
Net Revenue	**857**	**129**	**8,779**	**63**
Expenditure				
Personnel	1,151	212	14,534	1,028
Outsourced Personnel	0	0	7	(3)
Sub -Total Personnel	1,151	213	14,541	1,024
Other Outsourced Services	67	3	793	29
Clinical Supplies	269	(32)	3,031	(257)
Infrastructure & Non-Clinical	65	102	1,755	247
Total Operating Expenditure	**1,553**	**286**	**20,121**	**1,042**
Provider Payments	4,899	1	58,791	5
Corporate Services	104	0	1,231	18
Surplus/(Deficit)	**(5,699)**	**417**	**(71,363)**	**1,128**

FTE				
Medical	(0.2)	4.1	3.2	0.6
Nursing	80.2	4.1	79.9	3.5
Allied Health	63.7	6.7	65.2	2.6
Support	0.0	0.0	0.0	0.0
Management / Admin	19.0	1.8	18.2	2.5
Total FTE	**162.7**	**16.6**	**166.5**	**9.2**



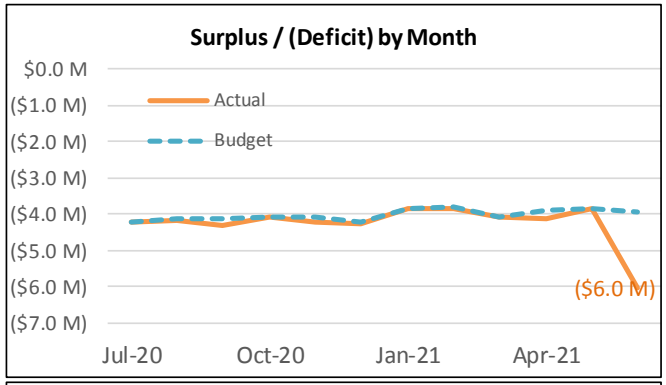


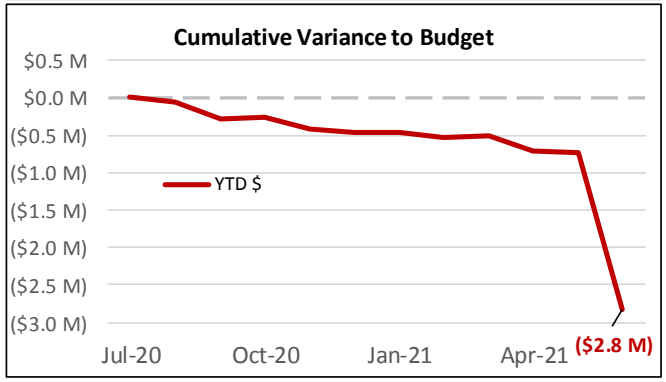


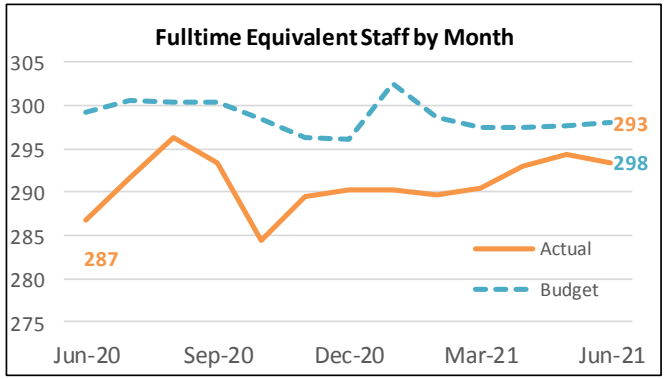
Te Uru Rauhī – Mental Health and Addiction Services

$000	June 2021 Actual	June 2021 Variance to Budget	Year End Forecast	Year End Variance to Budget
Net Revenue	**69**	**38**	**543**	**174**
Expenditure				
Personnel	4,430	(1,934)	30,106	(135)
Outsourced Personnel	453	(324)	4,936	(3,447)
Sub -Total Personnel	4,883	(2,259)	35,042	(3,582)
Other Outsourced Services	60	(19)	697	(209)
Clinical Supplies	19	2	251	(13)
Infrastructure & Non-Clinical	183	2	2,097	90
Total Operating Expenditure	**5,145**	**(2,274)**	**38,086**	**(3,714)**
Provider Payments	955	135	13,428	703
Corporate Services	14	0	164	0
Surplus/(Deficit)	**(6,045)**	**(2,102)**	**(51,135)**	**(2,837)**

FTE				
Medical	21.1	5.1	16.2	9.9
Nursing	185.0	(11.4)	186.4	(11.5)
Allied Health	51.8	4.3	48.5	7.1
Support	0.0	0.0	0.0	0.0
Management / Admin	35.5	6.6	40.3	1.8
Total FTE	**293.4**	**4.6**	**291.4**	**7.3**



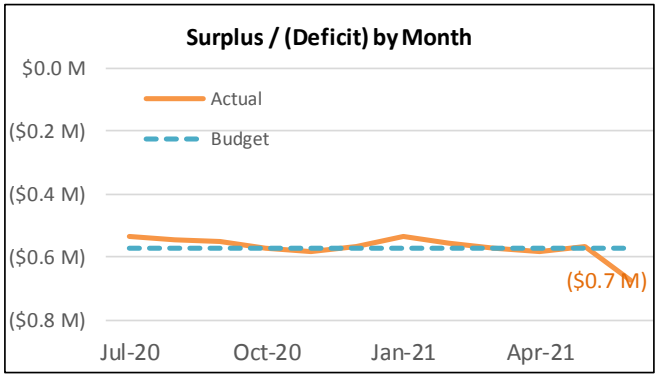


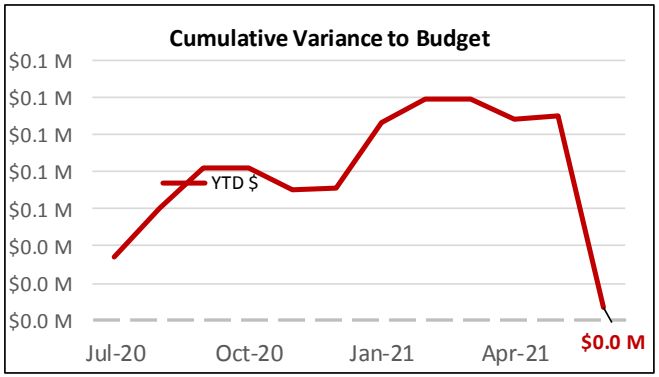


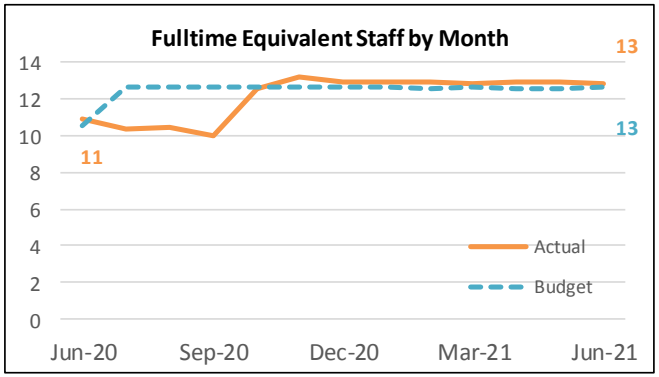
Pae Ora – Paiaka Whaiora Directorate

$000	June 2021 Actual	June 2021 Variance to Budget	Year End Forecast	Year End Variance to Budget
Net Revenue	**128**	**1**	**1,708**	**253**
Expenditure				
Personnel	106	9	1,171	139
Outsourced Personnel	0	0	0	0
Sub -Total Personnel	106	9	1,171	139
Other Outsourced Services	100	(100)	100	(100)
Clinical Supplies	0	0	2	0
Infrastructure & Non-Clinical	26	(14)	187	(44)
Total Operating Expenditure	**232**	**(105)**	**1,460**	**(5)**
Provider Payments	569	1	7,080	(241)
Corporate Services	0	0	0	0
Surplus/(Deficit)	**(673)**	**(103)**	**(6,831)**	**7**

FTE				
Medical	0.0	1.2	0.2	1.0
Nursing	2.0	(0.0)	1.8	0.2
Allied Health	4.3	(1.7)	4.0	(1.3)
Support	0.0	0.0	0.0	0.0
Management / Admin	6.4	0.3	6.3	0.5
Total FTE	**12.8**	**(0.2)**	**12.2**	**0.4**



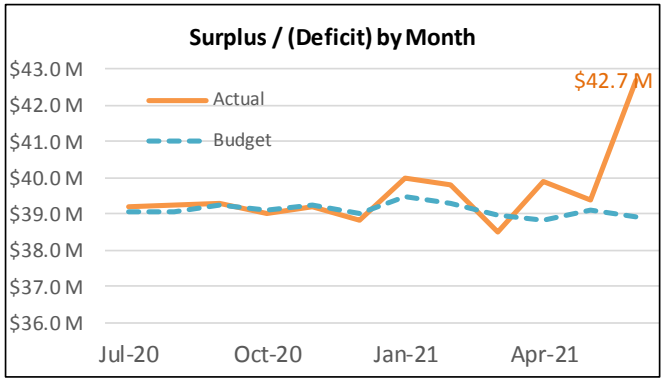


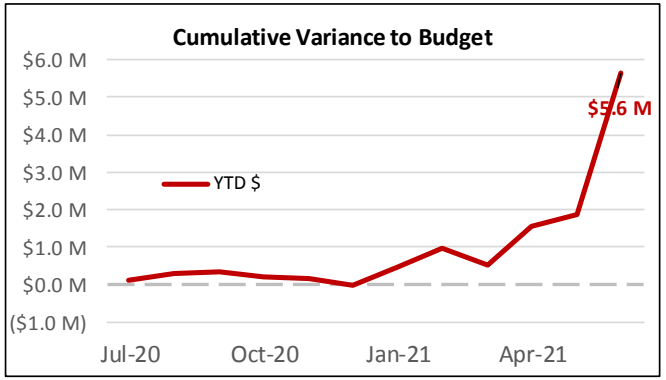


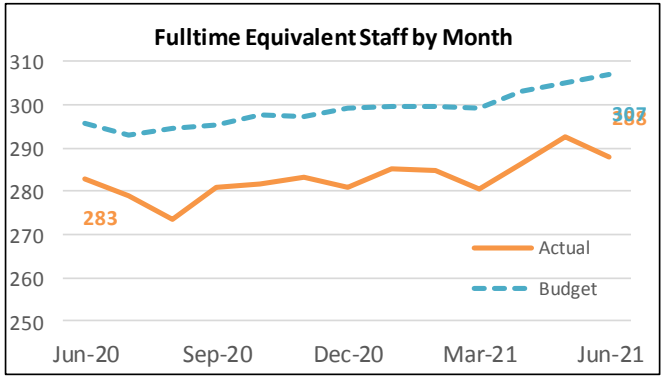
Corporate and Professional Services

$000	June 2021 Actual	June 2021 Variance to Budget	Year End Forecast	Year End Variance to Budget
Net Revenue	**55,826**	**(562)**	**680,187**	**3,591**
Expenditure				
Personnel	2,617	59	30,155	442
Outsourced Personnel	135	(77)	1,582	(915)
Sub -Total Personnel	2,752	(18)	31,737	(473)
Other Outsourced Services	178	(5)	2,138	(67)
Clinical Supplies	102	(24)	1,029	(110)
Infrastructure & Non-Clinical	5,906	(1,158)	56,555	(538)
Total Operating Expenditure	**8,938**	**(1,205)**	**91,458**	**(1,188)**
Provider Payments	5,587	5,531	130,196	3,226
Corporate Services	(1,372)	0	(16,462)	0
Surplus/(Deficit)	**42,673**	**3,764**	**474,995**	**5,629**

FTE				
Medical	13.1	(2.6)	9.7	0.5
Nursing	41.8	1.3	44.6	(2.5)
Allied Health	6.8	(1.2)	5.4	0.2
Support	13.2	0.1	13.1	0.2
Management / Admin	212.9	21.5	210.2	17.7
Total FTE	**287.9**	**19.1**	**283.0**	**16.1**



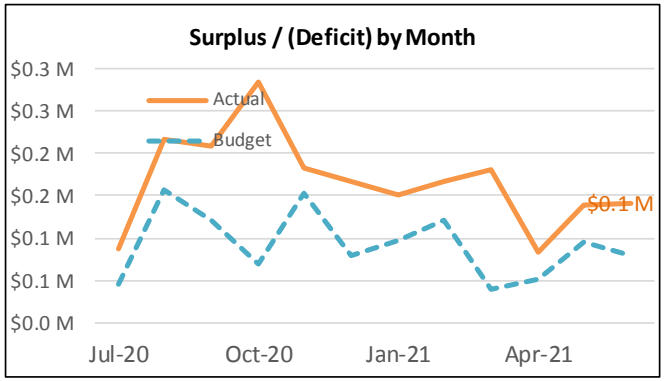


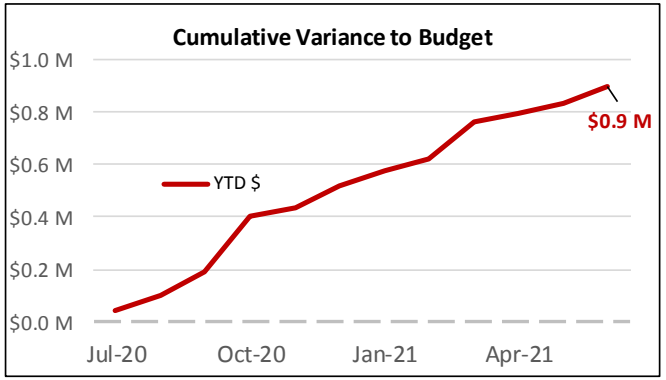


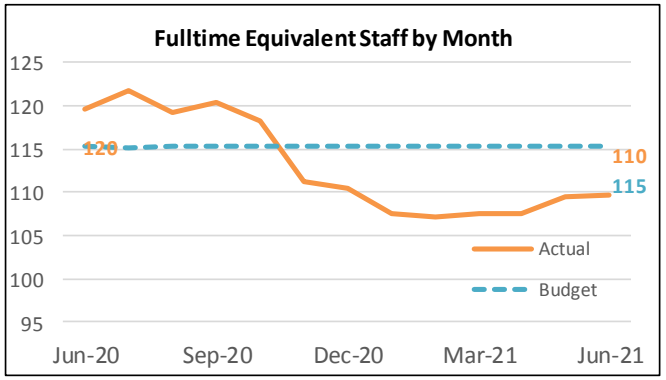
Enable New Zealand

$000	June 2021 Actual	June 2021 Variance to Budget	Year End Forecast	Year End Variance to Budget
Net Revenue	**3,241**	**247**	**39,038**	**3,104**
Expenditure				
Personnel	716	54	8,697	410
Outsourced Personnel	50	(22)	394	(70)
Sub -Total Personnel	766	31	9,090	340
Other Outsourced Services	0	9	43	60
Clinical Supplies	6	(0)	70	(0)
Infrastructure & Non-Clinical	2,277	(225)	27,227	(2,606)
Total Operating Expenditure	**3,049**	**(185)**	**36,431**	**(2,206)**
Provider Payments	0	0	0	0
Corporate Services	50	0	600	0
Surplus/(Deficit)	**141**	**62**	**2,008**	**898**

FTE				
Medical	0.0	0.0	0.0	0.0
Nursing	0.0	0.0	0.0	0.0
Allied Health	22.9	8.2	22.1	8.9
Support	17.4	(1.4)	17.6	(1.6)
Management / Admin	69.3	(1.0)	72.7	(4.4)
Total FTE	**109.7**	**5.7**	**112.5**	**2.9**







Holidays Act

$000	June 2021 Actual	June 2021 Variance to Budget	Year End Forecast	Year End Variance to Budget	Life to date Actual Since May 2010
Expenditure					
Personnel	35,126	(35,126)	36,522	(36,522)	47,519
Outsourced Personnel	132	(132)	603	(603)	603
Sub -Total Personnel	35,259	(35,259)	37,125	(37,125)	48,122
Other Outsourced Services	0	0	0	0	0
Clinical Supplies	0	0	0	0	0
Infrastructure & Non-Clinical	249	(249)	1,360	(1,360)	1,360
Total Operating Expenditure	**35,507**	**(35,507)**	**38,485**	**(38,485)**	**49,482**
Surplus/(Deficit)	**(35,507)**	**(35,507)**	**(38,485)**	**(38,485)**	**(49,482)**

COVID-19

$000	June 2021 Actual	June 2021 Variance to Budget	Year End Forecast	Year End Variance to Budget	Life to date Actual Since March 2020
Net Revenue	**1,136**	**1,136**	**4,667**	**4,667**	**5,377**
Expenditure					
Personnel	349	(349)	1,397	(1,397)	4,607
Outsourced Personnel	51	(51)	179	(179)	248
Sub -Total Personnel	399	(399)	1,575	(1,575)	4,855
Other Outsourced Services	322	(322)	1,877	(1,877)	2,755
Clinical Supplies	11	(11)	83	(83)	426
Infrastructure & Non-Clinical	404	(404)	1,232	(1,232)	3,226
Total Operating Expenditure	**1,136**	**(1,136)**	**4,767**	**(4,767)**	**11,262**
Surplus/(Deficit)	**0**	**0**	**(100)**	**(100)**	**(5,886)**

APPENDIX TWO – CAPITAL EXPENDITURE

($000)		Budget	Year to Date Approvals	Year to Date Expenditure	Remaining Approved Expenditure	Remaining Unapproved Budget Available	Year End Expenditure Forecast	Forecast Variance to budget
Board Approvals								
SPIRE Project	Infrastructure, Clinical Equipment, IT	9,266	9,038	3,202	5,836	0	4,312	4,954
Mental Health Redevelopment	Infrastructure, Clinical Equipment, IT	8,290	8,186	129	8,057	0	585	7,705
EDOA / MAPU PODS	Infrastructure, Clinical Equipment, IT	4,000	6,000	238	5,762	0	302	3,698
Sub Station Project	Infrastructure	2,281	2,281	1,678	603	0	1,727	554
Acute Services Block	Infrastructure Planning	700	700	(335)	700	0	0	700
Linear Accelerator Replacement	Clinical Equipment	4,344	4,344	3,502	842	0	4,302	42
Fluoroscopy	Clinical Equipment	1,540	1,640	7	1,633	0	407	1,133
Clinical-Monitors	Clinical Equipment	1,100	88	90	(2)	1,012	90	1,010
Laparoscopic Equipment	Clinical Equipment	670	670	91	579	0	670	0
RHIP	Information Technology	1,623	1,623	1,016	607	0	1,254	369
RiskMan	Information Technology	1,097	0	0	0	1,097	0	1,097
Programme of Change Mental Health & Addictions	Information Technology & Furniture and Fittings (Approval $2.802k split 20/21 $0.89m & 21/22 $1.905m)	897	897	92	805	0	250	647
Health System Catalogue-Transferred to Prepayments	Information Technology	600	1,031	421	610	0	487	113
TOTAL Board Approvals		**36,408**	**36,498**	**10,131**	**26,032**	**2,109**	**14,386**	**22,022**
Management Approvals - Specific Items								
Medical Imaging Equipment - Various	Clinical Equipment	500	0	0	0	500	300	200
Anaesthetic Machines & Monitor Replacement	Clinical Equipment	360	0	0	0	360	0	360
Fundus Camera & Microscope	Clinical Equipment	350	242	0	242	108	50	300
Cardiograph Image Vault	Clinical Equipment	250	0	0	0	250	0	250
Decarbonisation Project	Infrastructure	414	414	230	184	0	414	0
Children's Pressure Room	Infrastructure	400	0	0	0	400	0	400
Front Door Project	Infrastructure	314	150	126	24	0	126	188
Digital Workplace Programme	Information Technology	1,850	1188	1,313	(125)	0	1,418	432
Integration Strategy Implementation (IPaaS)	Information Technology	850	0	0	0	850	250	600
Planned Care - Scope	Information Technology	596	0	0	0	596	0	596
eReferrals (Triage)	Information Technology	585	123	117	6	462	50	535
Digitisation of Clinical Records	Information Technology	452	332	8	324	120	50	402
Website Upgrade	Information Technology	425	0	0	0	425	0	425
WebPASaaS Design & Implementation	Information Technology	400	16	0	16	384	0	400
ICU Equipment funding by MoH	Clinical Equipment	0	690	690	0	0	690	(690)
Theatre Equipment funding by MoH	Clinical Equipment	0	52	52	0	0	52	(52)
Covid Testing Van	Vehicles	0	195	0	195	0	195	(195)
Planned Care - Production Planning	Information Technology/Clinivcal Equipment	300	0	0	0	300		300
Management Approvals - Specific Items		**8,046**	**3,402**	**2,536**	**866**	**4,755**	**3,595**	**4,451**
Management Approvals - Pooled Items								
Clinical & Other Equipment	Clinical Equipment	2,790	2,063	1,423	640	986	1,833	957
Facilities & Infrastructure	Infrastructure	4,159	2,111	1,285	826	48	1,150	3,009
Information Technology	Information Technology	1,583	2,529	2,802	(273)	0	2,945	(1,362)
Covid-19	Various	714	936	936	0	0	936	(222)
Enable NZ	Various	1,000	28	28	0	972	150	850
Management Approvals - Pooled Items		**10,246**	**7,667**	**6,474**	**1,193**	**2,006**	**7,014**	**3,232**
TOTAL Against 2020/21 Capex Plan		**54,700**	**47,567**	**19,141**	**28,091**	**8,870**	**24,995**	**29,705**
Approvals against Prior Year Capex Plans			4,311	2,355	1,956	0	2,334	1,977
TOTAL		**54,700**	**51,878**	**21,496**	**30,047**	**8,870**	**27,329**	**31,682**
20/21 Budgeted Depreciation		24,053						
Capital Funding Support		24,538						
		48,591						

BOARD REPORT

For:

X	Approval
	Endorsement
	Noting

To	Board
Author	Darryl Ratana, Deputy Chief Financial Officer
Endorsed by	Finance, Risk and Audit Committee Neil Wanden, General Manager, Finance and Corporate Services
Date	28 July 2021
Subject	**Finance Report – May 2021**

Key questions the Board should consider in reviewing this paper:

- Is the current financial performance and trend in performance sustainable?
- Are the unfunded risks from COVID-19 and Holidays Act compliance manageable in the near term?
- Are the variations from budget sufficiently well explained and reasonable?
- Is there key financial information needed for governance that is not included in this report?
- Is the DHB able to trade solvently?

RECOMMENDATION

It is recommended that the Board:

- **note** that this report was endorsed by the Finance, Risk and Audit Committee at their 27 July meeting and no concerns were raised
- **note** that the month operating result for May 2021 is a surplus before one-off items of $0.219m, which is $0.735m favourable to budget
- **note** that the year to date result to 31 May 2021 is a surplus before one-off items of $0.399m, which is $3.857m favourable to budget
- **note** that year to date to 31 May 2021 COVID-19 related net costs of $0.100m and unbudgeted Holidays Act related costs of $2.978m have been incurred. Including these one-off costs results in a year to date deficit after exceptional items of $2.680m, which is $0.779 favourable to budget
- **note** that the total available cash and equivalents of $45.9m as at 31 May 2021 is sufficient to support liquidity requirements
- **approve** the May financial report.

Strategic Alignment This report is aligned to the DHB's strategy and key enabler, 'Stewardship'.

BOARD REPORT

1. REPORT AT A GLANCE

The result for May 2021 is a surplus before one-off items of $0.219m, which is $0.735m favourable to budget.

Favourable to Budget | Close to, or on Budget | Adverse to Budget

Month to Date

Surplus/(Deficit)
$0.2m
Budget Variance
$0.735m
142.5%

FTEs
2,402
Budget Variance
27
1.1%

Capex
$2.4m
Budget Variance
$0.6m
20.2%

Cash & Deposits Movement
($2.8m)
Budget Variance
($1.1m)
(64.7%)

Month Successes

* Favourable revenue
* Medical Staff close to budget with adverse Outsourced offset by own staff vacancies
* Healthly results aganst budget for most Directorates
* FTEs within budget with the exception of nursing

Month Challenges

* Adverse Acute and Elective
* Adverse nursing costs - Outsourced and own staff
* Adverse Treatment supplies, instrument & pharmaceuticals
* Adverse Infrastruture and Non-Clinical costs
* Capex well behind budget but has a positive impact on cash

Forecast Accuracy

Actual result for May favourable by $0.343m to the forecast anticipated for the month.

Year to Date

Surplus/(Deficit)
$0.4m
Budget Variance
$3.857m
111.5%

FTEs
2,356
Budget Variance
51
2.1%

Capex
$20.3m
Budget Variance
$27.9m
57.9%

Cash & Deposits
$45.9m
Budget Variance
$31.7m
223.2%

Current Ratio
1.01
Budget Variance
0.20

Year to Date Trends

* Favourable Planned Care The current level of activity is unlikely to continue.
* Personnel Costs adverse to budget due to nursing. FTE gap to budget is closing.
* Positive Cluster (WC&Y, PPCH, CSTS), Enable NZ and Corporate and Professional contributions.
* Adverse IT depreciation that is offset by favourable depreciation else where.
* Adverse Acute and Elective and Mental Health and Addictions Service (MHAS).

Potential Budget Risks

Eight Risks in Total. No change since last month

Four Low Risks (no change)
Four Tolerable Risks (No change)
Nil Emerging Risk (no change)
Nil Risk Materialised (no change)

Year End Forecast

Surplus/(Deficit)
($0.8m)
Budget Variance
$4.07m
82.9%

FTEs
2,363
Budget Variance
47
2.0%

Capex
$27.3m
Budget Variance
$26.2m
49.0%

Cash & Deposits
$26.6m
Budget Variance
$19.0m
247.5%

Current Ratio
0.85
Budget Variance
0.20

Year End Forecast

This forecast was provided to the MoH in June and includes May year to date actuals.

A year end deficit before one off items that is $4.1m favourable to budget is projected. This is prior to absorbing an estimated $38.5m of unbudgeted Holidays Act and Covid-19 costs.

Significant challenges include, Acute and Elective and MHAS. HAR (Healthy Ageing) is now back on track after a number of monthly positive results. MHAS has stablised over the last two months.

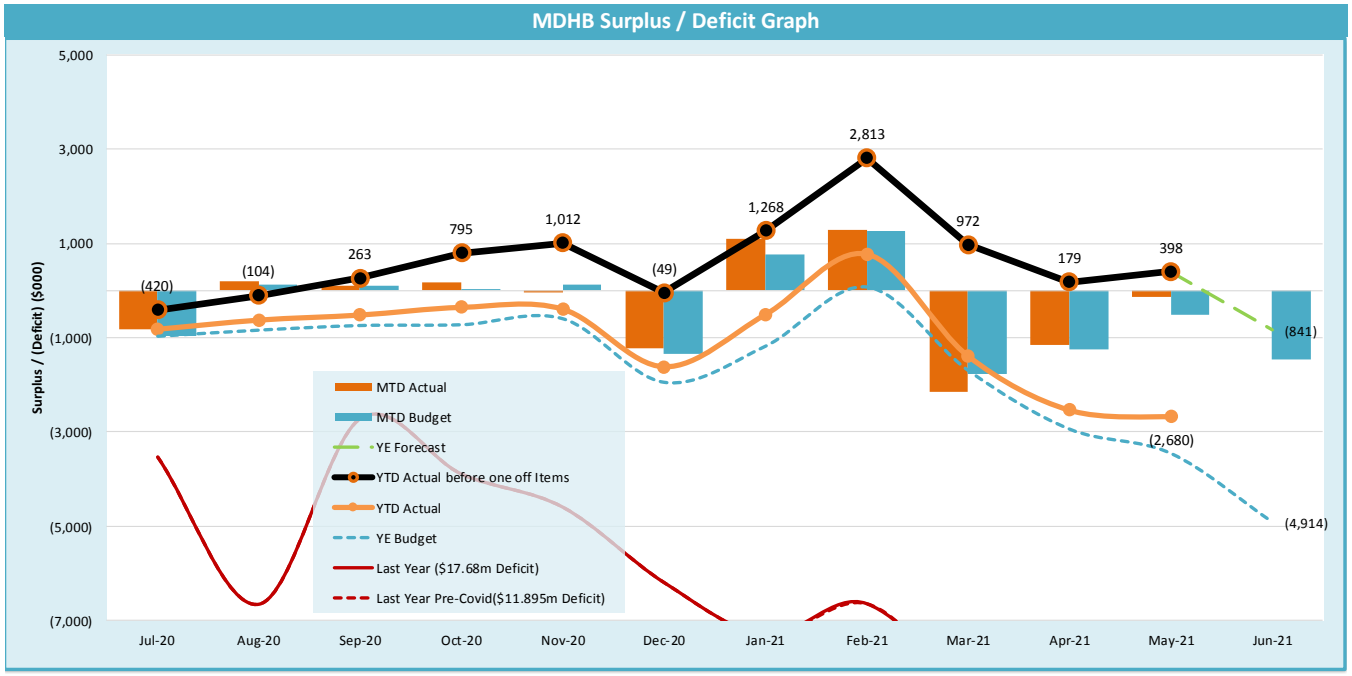
While projected employed FTEs are lower than budget, this is partially offset by outsourced staff. The June 2021 FTEs are anticipated to be at 2,437. This is 35 more FTE than the current month and unlikely to be acheived.

The current forecast for capital expenditure and cash balances reflects delays in capital projects leading to a positive year to date cash position.

The Current Ratio is a measure of liquidity. It is defined by the Ministry of Health as current assets over current liabilities (excluding employee entitlement provisions). As a comparison, the latest reported average for peer DHBs is 0.6

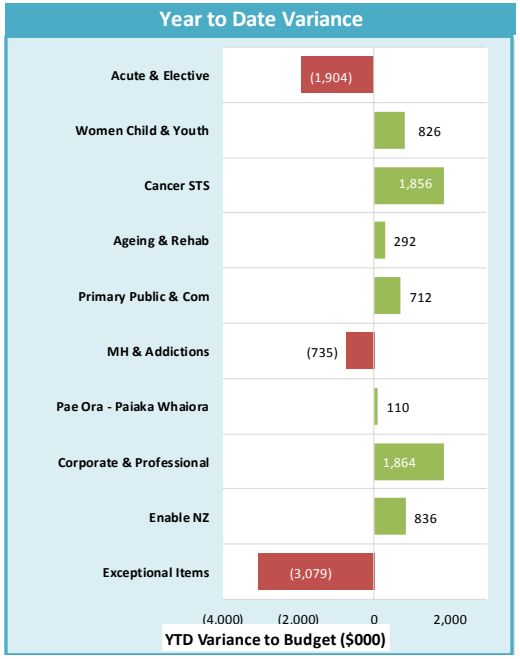
BOARD REPORT

MDHB Surplus / Deficit Graph



Month to Date Variance

Year to Date Variance



Year End Variance

2. FINANCIAL COMMENTARY

Adverse variances are in brackets unless stated otherwise.

2.1 Financial Performance

The MidCentral District Health Board (MDHB) result for May 2021 is a surplus before one-off items of $0.219m and is $0.735m favourable to budget. Net Revenue for the month is $2.745m favourable to budget and is partially offset by expenditure, which is $2.053m adverse to budget. The year to date result is a surplus of $0.399m, which is $3.857m favourable to budget.

Year to date COVID-19 related net costs of $0.100m and unbudgeted Holidays Act related costs of $2.978m have been incurred. This results in a year to date deficit of $2.680m when these one-off costs are included.

The financial performance to date and projected results for the remaining month of the financial year suggests the budget will be outperformed at an operating level before the inclusion of the Holidays Act, COVID-19 and any year-end valuations are considered. The current forecast suggests a year-end deficit before one-off items of $0.841m, which is $4.073m favourable to budget.

The Statement of Financial Performance is shown in the following table. Unbudgeted costs relating to the Holidays Act and COVID-19 are disclosed separately to show the underlying performance.

BOARD REPORT

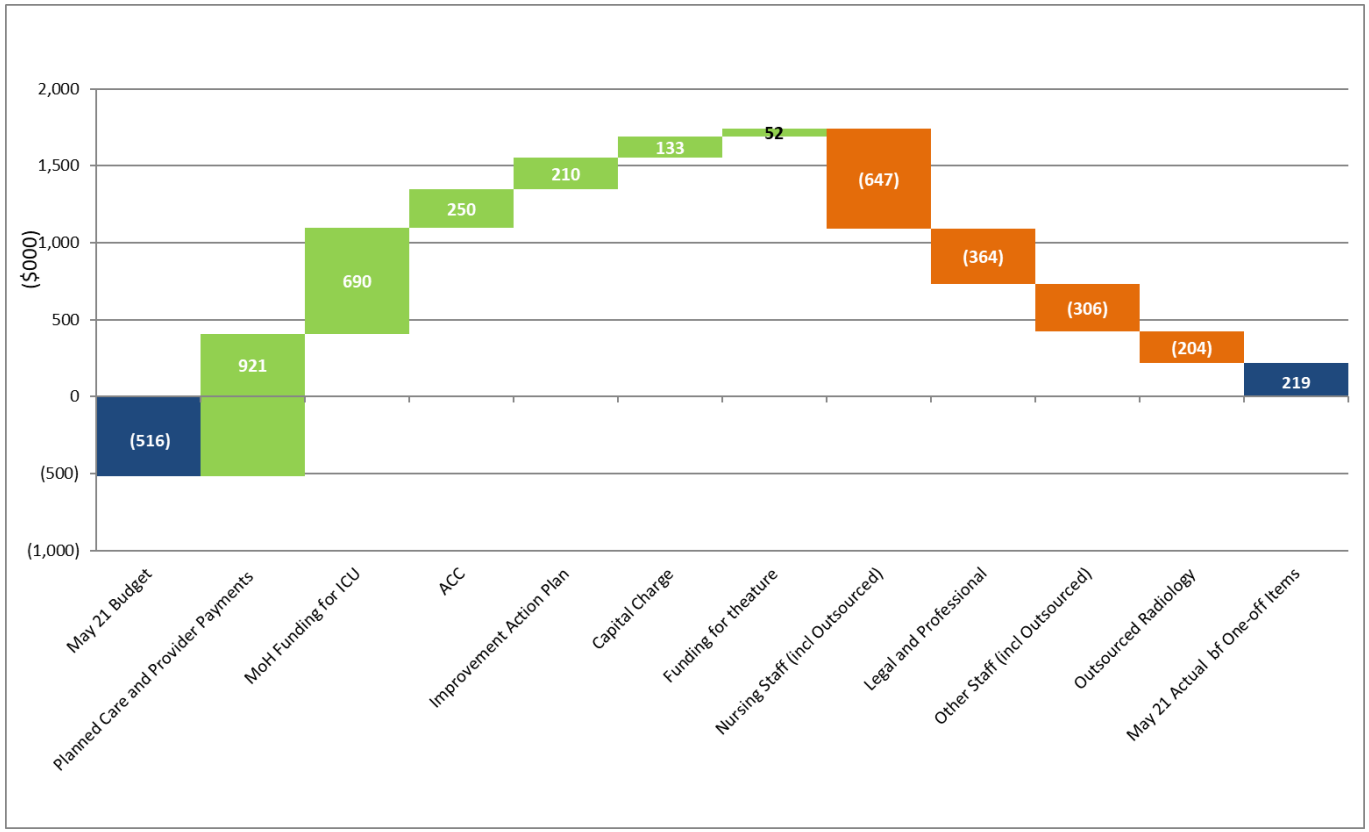
$000	May 2021			Year to date			Year End		
	Actual	Budget	Variance	Actual	Budget	Variance	Current Forecast	Budget	Variance
Net Revenue	**63,096**	**60,351**	**2,745** ✓	**676,102**	**663,746**	**12,356** ✓	**737,057**	**724,207**	**12,850** ✓
Expenditure									
Medical	6,701	6,958	257 ✓	69,956	75,520	5,564 ✓	76,676	82,828	6,152 ✓
Nursing	9,095	8,501	(594) ✗	96,839	92,823	(4,016) !	105,904	101,337	(4,567) !
Allied Health	3,151	3,200	49 ✓	32,889	34,846	1,957 ✓	36,144	38,251	2,107 ✓
Support	155	151	(4) !	1,600	1,684	84 ✓	1,764	1,848	84 ✓
Management / Admin	3,204	3,092	(112) !	32,911	33,627	716 ✓	36,372	36,921	549 ✓
Personnel	22,307	21,902	(405) !	234,195	238,500	4,305 ✓	256,860	261,186	4,326 ✓
Outsourced Personnel	863	315	(548) ✗	10,355	3,460	(6,895) ✗	11,098	3,788	(7,311) ✗
Sub -Total Personnel	23,170	22,217	(953) !	244,550	241,961	(2,590) !	267,958	264,974	(2,984) !
Other Outsourced Services	2,220	2,043	(177) ✗	25,474	22,452	(3,022) ✗	27,837	24,540	(3,297) ✗
Clinical Supplies	5,119	4,958	(161) !	56,624	54,422	(2,203) !	62,050	59,539	(2,511) !
Infrastructure & Non-Clinical	6,525	5,975	(550) ✗	65,311	64,880	(431) !	71,505	70,889	(616) !
Provider Payments	26,031	25,820	(211) !	286,160	285,070	(1,089) !	311,095	310,890	(205) !
Total Operating Expenditure	**63,065**	**61,012**	**(2,053)** !	**678,120**	**668,785**	**(9,335)** !	**740,445**	**730,831**	**(9,613)** !
Operating Surplus/(Deficit)	**31**	**(661)**	**692** ✓	**(2,018)**	**(5,039)**	**3,021** ✓	**(3,387)**	**(6,624)**	**3,237** ✓
Enable Contribution	188	145	43 ✓	2,416	1,580	836 ✓	2,546	1,710	836 ✓
Surplus/(Deficit) Before One-Off Items	**219**	**(516)**	**735** ✓	**399**	**(3,459)**	**3,857** ✓	**(841)**	**(4,914)**	**4,073** ✓
Holidays Act	(362)	0	(362) ✗	(2,978)	0	(2,978) ✗	(38,349)	0	(38,349) ✗
Covid-19	(0)	0	(0) ✗	(100)	0	(100) ✗	(100)	0	(100) ✗
Surplus/(Deficit)	**(143)**	**(516)**	**373** ✓	**(2,680)**	**(3,459)**	**779** ✓	**(39,291)**	**(4,914)**	**(34,377)** ✗

FTE									
Medical	359.8	379.2	19.4 ↓	344.4	377.7	33.3 ↓	346.0	378.4	32.3 ↓
Nursing	1,110.0	1,092.7	(17.3) →	1,105.1	1,085.3	(19.8) →	1,106.6	1,085.7	(20.9) →
Allied Health	434.2	434.7	0.6 ↓	417.5	428.0	10.5 ↓	418.3	428.8	10.5 ↓
Support	29.4	32.2	2.8 ↓	29.8	32.3	2.5 ↓	30.0	32.3	2.3 ↓
Management / Admin	468.6	489.9	21.3 ↓	459.3	484.0	24.7 ↓	461.9	484.7	22.8 ↓
Total FTE	**2,401.9**	**2,428.7**	**26.8** ↓	**2,356.1**	**2,407.4**	**51.3** ↓	**2,362.8**	**2,409.8**	**47.1** ↓

✓ Favourable to Budget
! Unfavourable to Budget but within 5%
✗ Unfavourable to Budget outside 5%
↓ FTE Below Budget
→ FTE Higher than Budge
↑ FTE Higher than Budget

Major variances to budget for the month of May drove the result as indicated in the following graph.

MAJOR VARIANCES TO BUDGET FOR THE MONTH



Revenue variances of significance for the month are as follows:

- Favourable revenue is related to Ministry funding of $0.210m for the Outpatient and Imaging Improvement Action Plan, $0.098m of Planned Care revenue and $0.250m of ACC funding. Despite a poor start to the year, ACC revenue is now $0.399m favourable year to date.
- In addition, favourable revenue is also the result of the timing of funding for the community provider contracts and Ministry funding received for the purchase of ICU equipment ($0.690m) and theatre equipment ($0.052m).

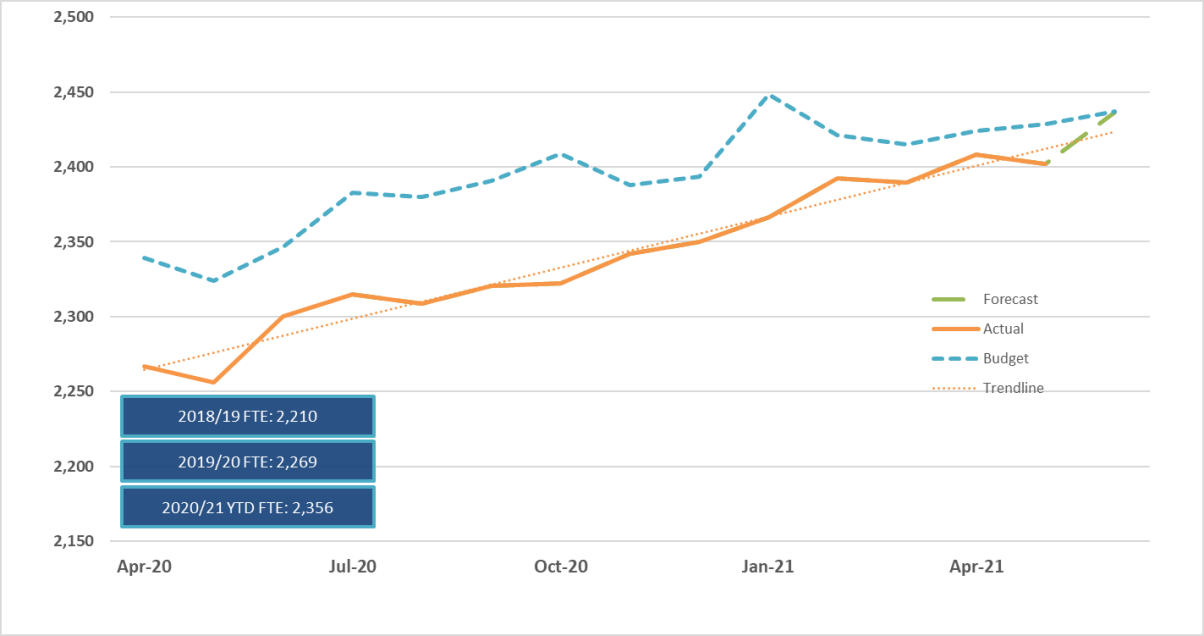
Full-time Equivalent staffing (FTE) for the month are as follows:

- Medical staff are below budget by 19 FTE for the month, with seven in Te Uru Arotau – Acute and Elective Specialist Services and nine in Te Uru Rauhī – Mental Health and Addiction Services. Ten long term radiologist vacancies are covered by outsourcing. Locums are covering vacancies in Te Uru Rauhī.

- Nursing staff are above budget by 17 FTE for the month, with 14 in Te Uru Arotau and nine in Te Uru Rauhī. These are partially offset by midwife vacancies in Te Uru Pā Harakeke – Healthy Women, Children and Youth Services.

  The filling of nursing vacancies in Te Uru Arotau has outpaced budget projections. Emergency Department nursing FTEs are ahead of budget by six FTE. The Te Uru Rauhī variance is in Ward 21 and STAR 1.
- While Allied Health FTEs are close to budget, Te Uru Arotau is above budget by 16 for the month and shows a gradual increase across the year. The increases have mainly been in Pharmacy Technicians, Radiology MRTs and Anaesthetic Technicians. These are offset by various vacancies in all other Directorates with Cluster functions.
- Management staff are below budget by 21 FTE for the month in Corporate and Professional Services. This includes several small variances across services, with the most significant being in Executive Services and Strategy, Planning and Performance.
- The table below shows the total FTEs by month for this year. The FTE forecast, represented in the graph as a green dotted line, suggests a trend towards budget. While the overall gap closes by year-end, this reflects nursing staff ahead of budget and other role types that have vacancies filled by outsourcing.

TOTAL EMPLOYED FTES BY MONTH



Personnel variances of significance and points to note are identified below:

- Except for administration staff, FTE variances primarily drive adverse personnel costs of $0.405m. Adverse administration staff costs are driven by staff training programmes that relate to all job categories.

- Favourable medical staff variances in Te Uru Rauhī of $0.244m are more than offset by locum costs. While Te Uru Arotau medical staff FTEs are favourable overall, Emergency Department FTEs that are greater than budget is driving an adverse Personnel variance for this service.

- The adverse nursing staff variance features in all Directorates with Cluster functions except for Te Uru Kiriora – Primary, Public and Community Service, which is favourable by $0.088m. The largest adverse variances are in Te Uru Arotau ($0.217m) and Te Uru Rauhī ($0.250m). This trend has been consistent for the majority of the year.

- Adverse administration staff costs are driven by staff training programmes related to all job categories but have been applied to administration only. Overall, expenditure on courses, conferences and professional staff fees are on budget for May. Year to date, spending on training is $1.703m favourable to budget largely related to staff being unable to attend overseas training courses.

- Outsourced personnel costs are $0.548m adverse to budget. This was mainly due to adverse Te Uru Rauhī locum costs ($0.224m) that are partially offset by favourable employed medical staff (also $0.224m). In addition, Digital Services outsourced staff are $0.132m due to the number of recent vacancies and a high level of activity. Outsourced nursing costs, which essentially represent specialling of patients, was adverse to budget for the month by $0.053m. Both this month and the previous month have been comparatively low when compared to previous periods.

Other variances of significance for the month are outlined as follows:

- Other Outsourced Services are adverse to budget due to Outsourced Radiology expenditure ($0.137m) and Crest Hospital for outsourced planned care ($0.072m), both of which impact Te Uru Arotau. In addition, Outsourced Radiology expenditure ($0.065m) features in Te Uru Mātai Matengau – Cancer Screening, Treatment and Support Services for breast screening activity.
- Adverse Clinical Supplies largely relate to Te Uru Arotau. The variances are in treatment supplies ($0.101m), implants plus instruments and equipment used in theatre ($0.056m) and in pharmaceuticals ($0.100m), where infliximab features heavily again this month.
- Infrastructure and Non-Clinical costs are $0.550m adverse to budget. The key causes of this variance are consultancy and legal fees ($348m) and the cost of Pharmacy stock, which is offset by sales and facility costs. There are several small variances for consultancy costs, with the most significant relating to executive support, valuation services for financial year-end and technology support for Digital Services. Infrastructure costs have benefited from financing charges which are due to the rate for the capital charge changing from 6.0 percent to 5.0 percent which is offset by decreased Ministry revenue to fund the charge.

2.2 Financial Performance by Service

The statement of 'Net Revenue and Expenditure by Service' is shown in the table below.

$000	May 2021			Year to date			Year End		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Acute & Elective Specialist S	(13,830)	(13,622)	(208) !	(149,589)	(147,685)	(1,904) !	(163,776)	(161,682)	(2,094) !
Healthy Women, Children an	(2,687)	(2,868)	181 ✓	(29,830)	(30,657)	826 ✓	(32,700)	(33,575)	875 ✓
Cancer Screening, Treatment	(3,492)	(3,673)	181 ✓	(38,186)	(40,042)	1,856 ✓	(41,724)	(43,813)	2,089 ✓
Healthy Ageing & Rehabiliati	(8,920)	(9,088)	168 ✓	(99,272)	(99,564)	292 ✓	(108,443)	(108,692)	249 ✓
Primary, Public & Community	(5,975)	(6,050)	75 ✓	(65,665)	(66,377)	712 ✓	(71,672)	(72,492)	820 ✓
Mental Health & Addictions	(3,852)	(3,840)	(13) !	(45,090)	(44,355)	(735) !	(49,264)	(48,298)	(965) !
Pae Ora - Paiaka Whaiora	(567)	(570)	2 ✓	(6,158)	(6,268)	110 ✓	(6,728)	(6,838)	110 ✓
Corporate & Professional Ser	39,406	39,100	306 ✓	432,322	430,458	1,864 ✓	471,519	469,366	2,153 ✓
Enable NZ	138	95	43 ✓	1,866	1,030	836 ✓	1,946	1,110	836 ✓
Surplus/(Deficit) Before On	**219**	**(516)**	**735** ✓	**399**	**(3,459)**	**3,857** ✓	**(841)**	**(4,914)**	**4,073** ✓
Exceptional Items	(362)	0	(362) ✗	(3,079)	0	(3,079) ✗	(38,450)	0	(38,450) ✗
Surplus/(Deficit)	**(143)**	**(516)**	**373** ✓	**(2,680)**	**(3,459)**	**779** ✓	**(39,291)**	**(4,914)**	**(34,377)** ✗

✓ Favourable to Budget ! Unfavourable to Budget but within 5% ✗ Unfavourable to Budget outside 5%

Items of note that impacted service financial performance for the month are outlined below. Further details are provided in Appendix One – Financial Performance by Service.

- Te Uru Arotau – Acute and Elective Specialist Services had an adverse result for the month of $0.208m despite having favourable revenue. Planned care revenue and ACC funding were $0.098m and $0.220m favourable to budget for the month. In addition, unbudgeted revenue of $0.210m for the Outpatient and Imaging Improvement Action Plan was received.

  Several expenditure items were adverse to budget, with the most noticeable being personnel costs ($0.522m), clinical supplies ($0.180m) and outsourced services ($0.186m). Personnel costs included annual leave not taken and planned vacancies in nursing and allied staff that have been filled. As with April, specialling costs in May were adverse to budget (by $0.035m), but relatively low when compared to activity in the last 12 months.

  Unfavourable clinical supply variances primarily relate to blood products used in theatre. Pharmaceuticals, particularly infliximab ($0.117m) also contributed to this variance. The increased complexity in acute demand with increased acuity in cardiac, delirium

and stroke patients continue. Radiology, Crest Hospital and the cost of health recovery beds are driving the Outsourced Services variance.

- Te Uru Pā Harakeke – Healthy Women, Children and Youth Services was favourable to budget for the month with adverse planned care revenue more than offset by variances in expenditure. Favourable outsourced services are due to lower than anticipated Crest Hospital and Auckland DHB paediatric clinics.
- The favourable month result for Te Uru Mātai Matengau – Cancer Screening, Treatment and Support Services was due to favourable revenue and clinical supplies, partially offset by adverse outsourced services and infrastructure expenses. Revenue was driven by breast screening services, where scanning activity was greater than planned. Favourable clinical supplies are largely due to an underspend in pharmaceuticals. Outsourced radiology for drug trials and increased breast screening volumes have driven Outsourced Services. Adverse Infrastructure expenses are due to Picture Archiving and Communication Systems (PACS) maintenance costs.
- The favourable variance in Te Uru Whakamauora – Healthy Ageing and Rehabilitation Services results from favourable community provider expenses. This continues an ongoing monthly trend that will continue to year-end. Adverse Infrastructure expenses is driven by meal and facility costs. Medical and Allied Health staff vacancies persist.
- Te Uru Kiriora – Primary, Public and Community Services is favourable to budget for the month by $0.168m with vacancies in Allied Health that are 6.4 FTE lower than budget. Allied Health vacancies occur in both Dental and Public Health. Attempts to recruit to positions continue, albeit there is recognition of national shortages in some occupations such as Dental Therapists.
- Te Uru Rauhī – Mental Health and Addictions Services is close to budget for the month. Adverse personnel costs (including outsourced personnel) of $0.233m are due to nursing costs in Ward 21 and the STAR ward. A combination of high bed numbers and increased specialling resulted in both a high level of ordinary time and overtime. Ward 21 continues to run over its resourced bed numbers due to demand. Outsourced Medical staff is $0.343m adverse, largely offset by Medical staff that is $0.224m favourable.

  Provider payments were favourable to budget for the month by $0.135m due to savings from provider contract rationalisation. While the year-end forecast for this service is for a $0.965m adverse variance to budget, this is before $0.855m of unspent funding recently returned by THINK Hauroa following a contract review process with them. This amount is held on the balance sheet.
- Corporate and Professional Services comprises all Executive and Enabler functions. The month result was due to favourable revenue partially offset by adverse expenditure in both staffing and community provider payments. Favourable staffing features in both Strategy, Planning and Performance as well as in the Professional and Executive enablers. Favourable Provider Payments are due to the revision and release of balance sheet provisions. Favourable revenue was due to additional funding for base electives.

- Exceptional Items contains organisation-wide costs of COVID-19 and Holidays Act. Both of these are unbudgeted. The budget assumption is that the Ministry will fund any reasonable and actual COVID-19 expenditure. In addition, the Ministry required all DHBs to remove Holidays Act costs from 2020/21 budgets. Refer to sections 2.3 and 2.4 below.

- The May 2021 result for Enable New Zealand is due to favourable income from trading activities and procurement rebates. Trading activities include direct sales, equipment hire, equipment refurbishment and freighting of complex equipment.

A Statement of Net Revenue and Expenditure by Division is shown in the table below.

$000	May 2021			Year to date			Year End		
	Actual	Budget	Variance	Actual	Budget	Variance	Forecast	Budget	Variance
Funding Division	2,197	1,896	301 ✓	23,191	20,734	2,457 ✓	25,785	22,522	3,263 ✓
MidCentral Provider	(2,089)	(2,507)	418 ✓	(26,773)	(25,223)	(1,550) ✗	(65,924)	(28,546)	(37,378) ✗
Enable NZ	138	95	43 ✓	1,866	1,030	836 ✓	1,946	1,110	836 ✓
Governance	(389)	0	(389) ✗	(964)	0	(964) ✗	(1,098)	0	(1,098) ✗
Surplus/(Deficit)	**(143)**	**(516)**	**373** ✓	**(2,680)**	**(3,459)**	**779** ✓	**(39,291)**	**(4,914)**	**(34,377)** ✗

✓ Favourable to Budget ! Unfavourable to Budget but within 5% ✗ Unfavourable to Budget outside 5%

2.3 Holidays Act

Year to date expenditure on the Holidays Act totals $2.978m. This is made up of expenditure on the compliance project of $1.678m and increases to the provision of $1.300m. Year-end expenditure is forecast to be $38.349m. It includes a year-end adjustment to reflect the re-assessment of the liability estimate based on the review undertaken by Ernst Young. The year-end balance sheet provision for staff remediation for Holidays Act breaches since May 2010 is currently forecast to be $47.0m. The overall quantum is consistent with other DHB findings in that the annual cost is *circa* two to three percent of total payroll costs.

It is important to note that the Ministry separates Holidays Act issues from the measurement of DHB performance and that DHBs were explicitly requested not to budget for this cost in the 2020/21 year. The Holidays Act is a national issue faced by all DHBs, and the expectation is that this will require separate funding to remediate. The Government has signalled that it will provide this funding once all DHBs are in a position to rectify. It is most likely that this will come as deficit support.

2.4 COVID-19

While net expenditure during May was minimal, this reflects $0.492m of immunisation funding offset by expenditure of the same quantum. Funding is for immunisation staff and facility costs to undertake vaccinations at the new city centre location. Staffing totalled 25 FTE for the month, and this will increase as immunisation activity expands. The year to date unbudgeted net expenditure

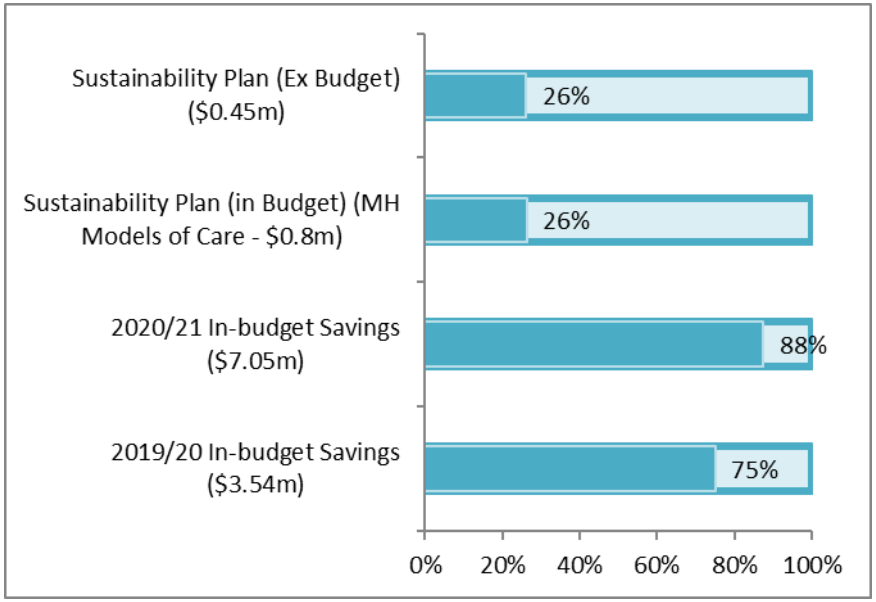
totals $0.100m, with the month movement related to fit testing of N95 masks. Year to date net expenditure will remain unchanged for the remainder of the year, assuming no further escalation of pandemic events and a full reimbursement of the immunisation programme.

The Ministry has provided advice on the funding model for the immunisation programme, which is in line with MDHB's expectations.

2.5 Sustainability and Savings Plan

The table below shows the year to date progress against the year-end target. Overall progress against the target is at 77 percent year to date. While it is unlikely the overall savings targets will be achieved, the DHB is operating well within budget when one-off items are excluded.

SUSTAINABILITY AND SAVINGS PLAN PROGRESS TO DATE



2.6 Year-End Forecast

The current forecast is that MDHB will end the year with an operating deficit of $0.841m, which is favourable to the budgeted deficit of $4.914m by $4.122m. Unbudgeted Holidays Act expenditure has been adjusted to reflect a re-valuation of the historical provision and now reflects the assessment undertaken by Ernst Young. This has increased the previous forecast for the Holidays Act by $34.7m and far exceeds our ability to absorb within the budget. It is important to note that the Ministry separates Holidays Act issues from the measurement of DHB performance.

The projected year-end cash and deposit balances is $26.6m, which is better than budget by $19.0m. This assumes significant capital expenditure in June. In reality this will be difficult to achieve given capital expenditure has been tracking behind budget throughout the year. It is likely that the actual cash balances will be higher than that projected.

A number of potential risks were identified and communicated during the budget process. If realised, these will affect our ability to achieve this year's budget targets. These risks are outlined in the following table, along with their ratings.

	Low Risk No concerns to date		Risk Unknown No evidence of risk to date. Keep in view		Risk Emerging		Risk likely to Materialise

Status	Potential Budget Risk	Current Status
	Achieving Sustainability and Saving Plan Objectives	
	While the financial impacts of some sustainability initiatives are not specifically budgeted, these must be achieved to help absorb any unplanned shocks to the DHB.	Overall savings are on target. While sustainability plan items are behind target, these are being offset by other savings that are ahead of target. An executive management lead has been assigned to each initiative to ensure they receive the appropriate level of attention and accountability. Regular reporting and monitoring of progress are in place.
	Ongoing Impacts of COVID-19	
	The impact of a second outbreak would be disruptive to the DHB and its budget. Staff annual leave will need to be carefully managed from both a staff wellbeing and financial perspective.	There have been no significant unfunded COVID-19 costs year to date. MoH funding advice for the immunisation programme appears to be in line with MDHB cost expectations.
	Timing of staff recruitment	
	The budget reflects average vacancy levels based on the assumption that not all positions will be able to be recruited. It also includes phasing adjustments on the basis that the need to fill positions will occur gradually throughout the year.	The year to date FTE variance is below budget by 14 FTE when all personnel costs (outsourced and employed) are considered. A gap will still exist at year-end, but the size of the gap has reduced during the year. Note that Nursing FTEs have been above budget for most of the year and are currently 20 FTE above budget. The outcome of CCDM reviews suggests additional nursing resource is required in several wards. The impact of this will impact on 2021/22.
	Future MECA settlements	
	The budget assumption is for a modest 1.5 percent increase in wage settlements based on the Governments expectation of restraint in the Public Sector given COVID-19 and its impact on the economy.	Year to date, overall average salary costs remain below budget expectations. DHBs are currently in negotiation with the NZNO over pay and conditions. The NZNO is planning further strike action in 2021/22.

	Achieving Planned Care targets	
	MoH proposed targets require an increase in output from MidCentral to achieve similar revenue levels as in 2019/20.	Planned Care activity has resulted in elective revenue is close to budget year to date.
	Hospital Capacity	
	Hospital bed capacity was increased during 2019/20 to accommodate growing demand. For 2020/21, several projects will commence being the SPIRE and EDOA / MAPU PODS projects. While the long-term benefit increases in future capacity, the short-term impact will lead to some disruption.	High bed occupancy has been experienced throughout the year to date. An experienced Project Director has been employed to help manage these projects, and planning is well underway. The PODs project is currently in the design phase and not expected to impact operations this year. SPIRE is further ahead. While some construction has commenced, only minor disruption is expected in this financial year.
	Holidays Act	
	Work to further define the financial impact is ongoing and will be revised as the project comes to a better understanding of the liability. The risk is that the liability will move because of that work, thereby affecting the planned deficit.	Year to date unbudgeted Holiday Act costs is currently being absorbed within the budget. However, significant year-end adjustments will occur that will not be able to be absorbed. This is now incorporated into the forecast. While this will impact the overall result, Holidays Act costs will be funded centrally by the Ministry of Health. For this reason, the risk rating has been changed to tolerable.
	WebPAS SaaS	
	A proposal to move from the current regional instance of WebPAS to a Software as a Service (SaaS) offering is being developed for consideration. Any move away from the current model may trigger the need to consider impairment.	The business case has experienced delays due to several issues, including data privacy. While work continues, the outcome of any proposal is uncertain at this point, and no financial impact will eventuate this financial year.

2.7 Financial Position

The main budget variances in the Balance Sheet at 31 May 2021 relate to timing differences in contractor payments and income received in advance, resulting in a higher than budgeted level of current liabilities, and the timing of capital expenditure being later than anticipated resulting in lower than budgeted non-current assets. Overall this has resulted in higher than budgeted cash on hand and deposits in current assets.

As at 31 May 2021, the total available cash and deposit balances were $45.893m. Significant capital expenditure is budgeted for the 2020/21 year, and the timing of this expenditure is currently running later than planned. The projected year-end cash and deposit balances have been revised to $26.648m, which is $18.982m favourable to the year-end cash and deposit balances budget of $7.666m.

$000	Jun-20	May-21		
	Actual	Actual	Budget	Variance
TOTAL ASSETS				
Non Current Assets	213,669	212,791	239,829	(27,038)
Current Assets	58,699	76,260	47,209	29,051
Total Assets	**272,368**	**289,051**	**287,037**	**2,014**
TOTAL EQUITY AND LIABILITIES				
Equity	158,340	162,612	173,445	10,833
Non Current Liabilities	7,713	7,014	7,312	298
Current Liabilities	106,315	119,425	106,280	(13,145)
Total Equity and Liabilities	**272,368**	**289,051**	**287,037**	**(2,014)**

2.8 Cash Flows

Overall cash flows reflect a favourable variance to budget of $31.659m as at 31 May 2021. Operating cash flows are favourable due to the net impact of working capital movements. Investing cash flows are favourable due to the timing of capital expenditure being later than budgeted. Financing activities are unfavourable due to equity injections for the SPIRE and mental health projects being later than budgeted.

$000	Jun-20	May-21		
	Actual	Actual	Budget	Variance
Net Cash Flow from Operating Activities	15,541	32,345	17,201	15,144 ✓
Net Cash Flows from Investing Activities	(19,204)	(20,071)	(48,203)	28,132 ✓
Net Cash Flows from Financing Activities	1,632	6,635	18,252	(11,617) ✗
Net increase / (decrease) in cash	**(2,031)**	**18,909**	**(12,750)**	**31,659** ✓
Cash at beginning of year	29,015	26,984	26,984	- ✓
Closing cash	**26,984**	**45,893**	**14,234**	**31,659** ✓

2.9 Cash, Investments and Debt

Cash and Investments

Trust and Special Funds are held in a separate BNZ account. These fall outside the shared banking arrangement with the BNZ that NZ Health Partnerships Limited (NZHP) sweeps daily. Surplus liquidity from the Enable New Zealand operating account is channelled through the main DHB accounts to obtain those benefits.

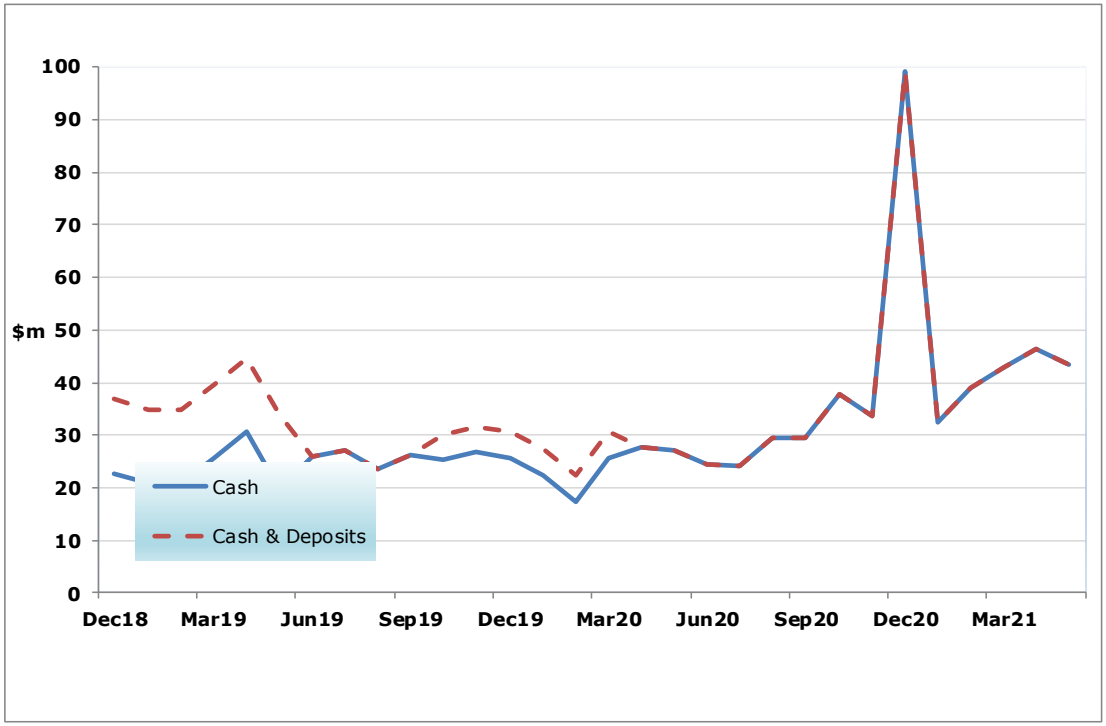
May-21	Rate	Value $000
NZHP Sweep Balance	0.75%	42,683
Cash in Hand and at Bank		2
Trust Accounts		2,490
Enable New Zealand		718
Cash Balances		45,893
Total Cash Balance		**45,893**

The cash reconciliation table below shows how cash has moved during the month.

Cash Reconciliation	May-21 $000	Year to date $000
Cash at April 2021	48,720	26,984
Surplus / (Deficit) for mth	(143)	(2,680)
Depreciation / Amortisation	2,137	21,252
Sale of fixed assets	1	31
Working capital movement	(3,329)	14,226
Share of associate net surplus/deficit	-	(126)
Capital expenditure	(2,369)	(20,280)
Loan/finance lease repayments	(29)	(251)
Trusts movement	47	(213)
Equity injections - capital	858	6,950
Cash Balance at month end	**45,893**	**45,893**

The chart below indicates the DHB's cash balance, excluding Investment and Trust Accounts. The spike in the December cash balance reflects the early payment of January revenue by the Ministry due to the timing of the Christmas holiday period.

CASH BALANCES



The DHB sector as a whole is experiencing liquidity pressure due to the continuation of operating deficits. NZHP, on behalf of DHBs, has been in ongoing discussion with the Ministry and Treasury on ways to resolve this and on the need for urgent deficit support equity injections to those DHBs who are insolvent. That resulted in an equity injection to the sector last October to accommodate payment timing. These pressures have not affected MDHB's operations to date. However, a resolution is necessary to enable the collective treasury management and optimisation to remain viable.

The Ministry has provided reassurance to the sector on the liquidity impacts of COVID-19. Despite this, COVID-19 will influence the ability to fund other initiatives in the sector in the near term.

The Ministry has also given reassurances that the cost of Holidays Act remediation will be funded separately at the time payments to remediate those employees impacted (past and present) are required to be made.

Net MDHB liquidity continues to be sufficient in the near term with steady levels. However, continuing operating deficits and planned capital investments are reducing the overall liquidity.

The Treasury and the Ministry are providing a funding allocation of $30m towards the $35m budget for the Mental Health Unit replacement and $27.5m for an expanded perioperative suite (SPIRE programme). The increased funding commenced this financial year with the bulk of the drawdowns occurring as major construction occurs over the next two years.

Treasury Policy and Ratios

There are currently no arrangements that necessitate monitoring against Treasury Policy parameters.

Debt and Leases

Debt previously held with the Energy and Efficiency Conservation Authority (EECA) has now been fully repaid. EECA has a Crown Efficiency Loan Scheme for assisting Government-funded organisations in taking measures to reduce their energy expenditure.

The MRI finance lease is held with MCL Capital which is a New Zealand owned and operated company offering leasing solutions to New Zealand public sector organisations.

Finance Leases	Start Date	Maturity	$'000	Equipment
MCL Capital	Jun-19	May-26	1,136	MRI Scanner

The finance lease allows the DHB to spread the cost of an asset over the term of the lease and preserves capital, minimises the draw on cash reserves and provides budget certainty with ownership at the lease expiry.

2.10 **Statement of Capital Expenditure**

Capital expenditure is below the overall budget, a trend that has continued from last year. Expenditure in May totalled $2.373m. This is largely due to the SPIRE project and $1.0m of ICU and anaesthetics equipment funded by the Ministry. Year to date, expenditure on capital is $20.284m. Note that year to date depreciation is $20.788m against a budget of $21.273m.

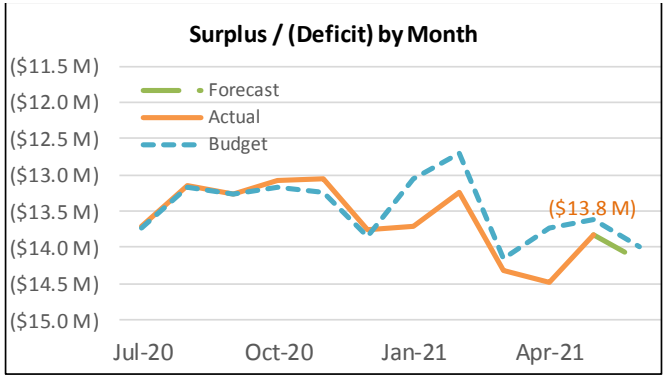
Further detail is provided in Appendix Two – Capital Expenditure.

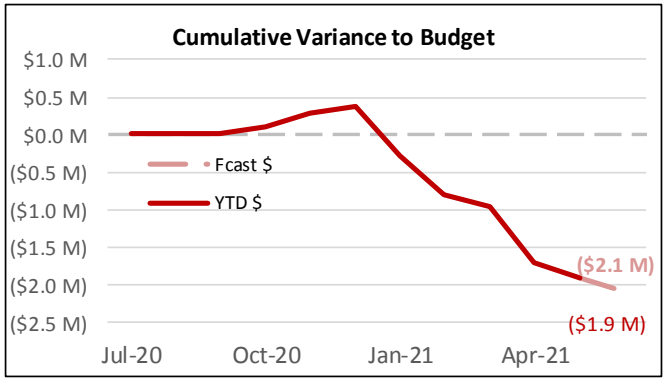
APPENDIX ONE – FINANCIAL PERFORMANCE BY SERVICE

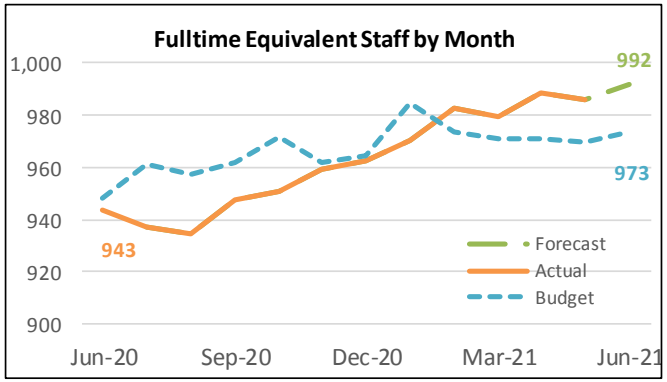
Te Uru Arotau – Acute and Elective Specialist Services

$000	May 2021 Actual	May 2021 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Forecast	Year End Variance to Budget
Net Revenue	**2,283**	**949**	**22,376**	**7,676**	**25,739**	**9,675**
Expenditure						
Personnel	9,878	(420)	103,232	(1,221)	113,074	(1,333)
Outsourced Personnel	176	(102)	2,819	(2,004)	3,001	(2,109)
Sub -Total Personnel	10,055	(522)	106,051	(3,224)	116,075	(3,442)
Other Outsourced Services	1,241	(186)	14,110	(2,504)	15,390	(2,704)
Clinical Supplies	3,144	(180)	35,304	(2,761)	40,028	(4,422)
Infrastructure & Non-Clinical	767	(275)	6,516	(1,133)	7,127	(1,243)
Total Operating Expenditure	**15,207**	**(1,162)**	**161,981**	**(9,623)**	**178,620**	**(11,812)**
Provider Payments	24	5	256	60	285	60
Corporate Services	883	0	9,728	(18)	10,611	(18)
Surplus/(Deficit)	**(13,830)**	**(208)**	**(149,589)**	**(1,904)**	**(163,776)**	**(2,094)**

FTE						
Medical	227.8	6.6	219.5	13.9	220.5	13.4
Nursing	485.5	(13.6)	480.7	(9.0)	481.3	(9.7)
Allied Health	137.6	(15.6)	127.1	(5.4)	127.4	(5.6)
Support	16.2	2.7	16.7	2.3	16.9	2.1
Management / Admin	119.1	3.2	119.6	2.6	119.8	2.4
Total FTE	**986.1**	**(16.7)**	**963.5**	**4.5**	**965.9**	**2.6**

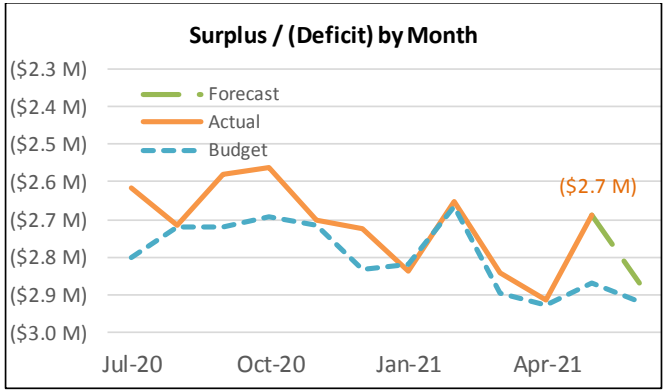


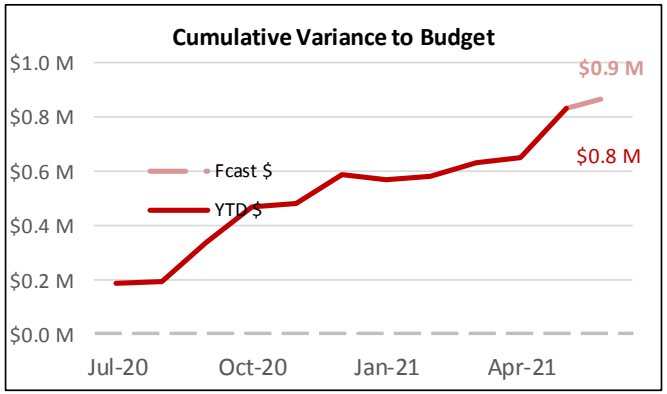




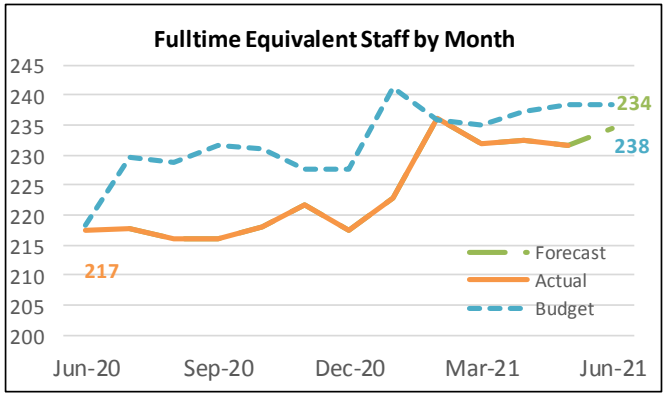
Te Uru Pā Harakeke – Healthy Women, Children and Youth Services

$000	May 2021 Actual	May 2021 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Forecast	Year End Variance to Budget
Net Revenue	**398**	**(61)**	**5,055**	**51**	**5,539**	**78**
Expenditure						
Personnel	2,237	104	23,703	1,145	26,001	1,225
Outsourced Personnel	34	(13)	614	(392)	650	(407)
Sub -Total Personnel	2,271	91	24,317	753	26,651	818
Other Outsourced Services	(6)	76	928	(160)	1,035	(195)
Clinical Supplies	234	37	3,085	(107)	3,383	(126)
Infrastructure & Non-Clinical	128	28	1,484	221	1,631	232
Total Operating Expenditure	**2,627**	**233**	**29,814**	**707**	**32,700**	**729**
Provider Payments	445	9	4,923	69	5,376	69
Corporate Services	14	0	149	0	162	0
Surplus/(Deficit)	**(2,687)**	**181**	**(29,830)**	**826**	**(32,700)**	**875**





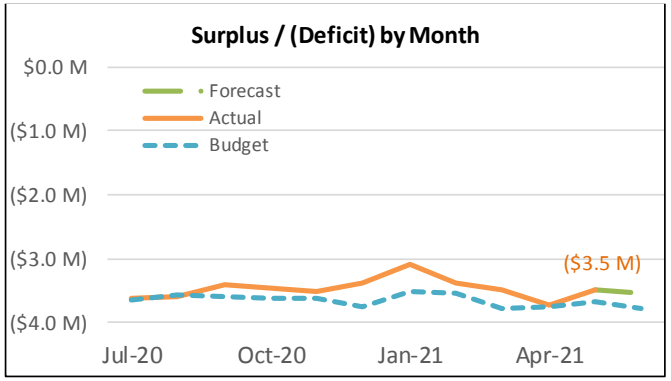
FTE						
Medical	44.7	(0.6)	42.0	2.7	42.1	2.6
Nursing	116.3	1.9	113.5	1.3	147.0	(31.9)
Midwives	35.0	3.5	32.9	3.9	35.5	1.4
Allied Health	14.7	2.1	14.9	0.9	15.1	0.8
Support	0.0	0.0	0.0	0.0	0.0	0.0
Management / Admin	20.9	(0.0)	20.5	0.5	20.5	0.4
Total FTE	**231.6**	**6.9**	**223.8**	**9.3**	**260.2**	**(26.7)**

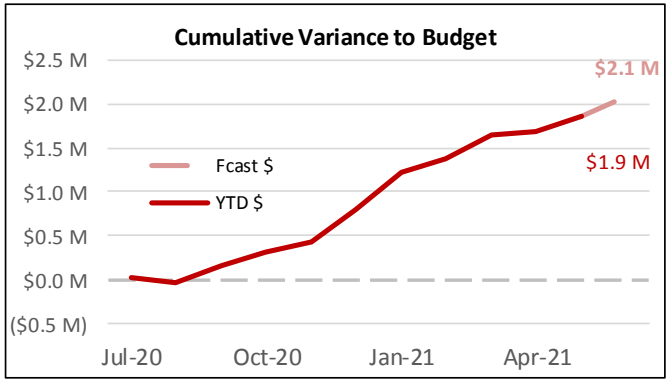


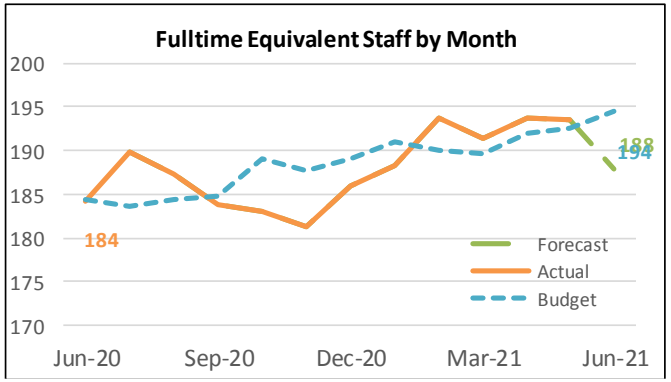
Te Uru Mātai Matengau – Cancer Screening, Treatment and Support Services

$000	May 2021 Actual	May 2021 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Forecast	Year End Variance to Budget
Net Revenue	**966**	**99**	**9,540**	**31**	**11,567**	**1,134**
Expenditure						
Personnel	1,948	11	20,357	869	22,208	1,079
Outsourced Personnel	7	(3)	79	(42)	82	(42)
Sub -Total Personnel	1,954	8	20,436	827	22,290	1,037
Other Outsourced Services	642	(55)	6,492	(41)	7,122	(69)
Clinical Supplies	1,124	125	12,498	1,215	14,837	165
Infrastructure & Non-Clinical	142	(13)	1,607	(224)	1,736	(226)
Total Operating Expenditure	**3,862**	**66**	**41,033**	**1,776**	**45,985**	**906**
Provider Payments	377	17	4,283	50	4,677	50
Corporate Services	219	0	2,410	0	2,629	0
Surplus/(Deficit)	**(3,492)**	**181**	**(38,186)**	**1,856**	**(41,724)**	**2,089**

FTE						
Medical	37.9	3.0	39.0	1.2	39.0	1.3
Nursing	58.0	(1.5)	56.0	(1.1)	56.0	(1.0)
Allied Health	66.0	(0.8)	63.2	1.0	63.2	1.2
Support	0.0	0.0	0.0	0.0	0.0	0.0
Management / Admin	31.5	(1.7)	30.1	(0.9)	30.1	(0.8)
Total FTE	**193.4**	**(0.9)**	**188.3**	**0.2**	**188.3**	**0.7**



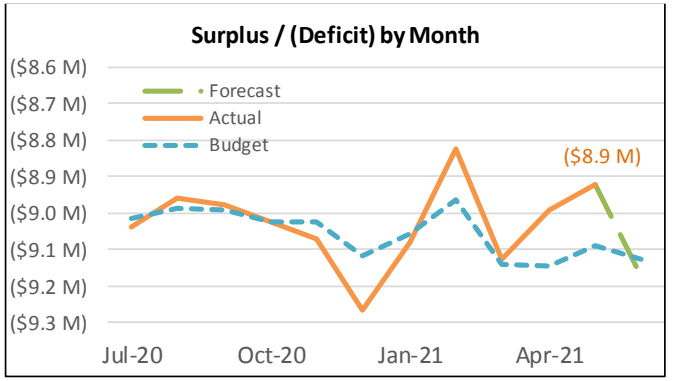


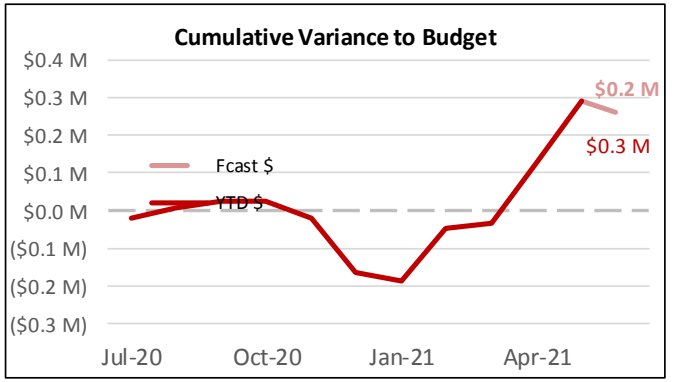


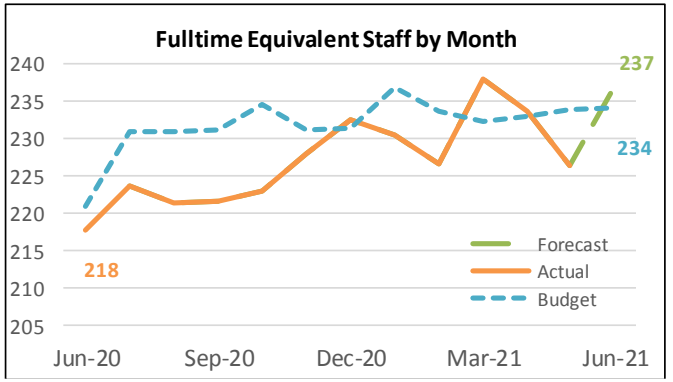
Te Uru Whakamauora – Healthy Ageing and Rehabilitation Services

$000	May 2021 Actual	May 2021 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Forecast	Year End Variance to Budget
Net Revenue	**461**	**35**	**4,891**	**220**	**5,333**	**220**
Expenditure						
Personnel	1,781	40	19,241	386	21,120	374
Outsourced Personnel	50	(12)	907	(493)	965	(512)
Sub -Total Personnel	1,830	28	20,148	(108)	22,085	(139)
Other Outsourced Services	45	3	622	(90)	671	(90)
Clinical Supplies	154	(9)	1,815	(224)	1,972	(231)
Infrastructure & Non-Clinical	151	(43)	1,388	(215)	1,502	(219)
Total Operating Expenditure	**2,180**	**(21)**	**23,973**	**(636)**	**26,231**	**(678)**
Provider Payments	7,112	153	79,213	708	86,479	708
Corporate Services	89	0	977	0	1,066	0
Surplus/(Deficit)	**(8,920)**	**168**	**(99,272)**	**292**	**(108,443)**	**249**

FTE						
Medical	14.0	4.1	14.9	3.0	14.9	3.0
Nursing	106.8	(1.9)	109.0	(4.1)	109.3	(4.5)
Allied Health	89.6	6.4	89.8	5.3	90.1	5.1
Support	0.0	0.0	0.0	0.0	0.0	0.0
Management / Admin	15.8	(1.0)	14.1	0.7	14.1	0.7
Total FTE	**226.2**	**7.7**	**227.7**	**4.9**	**228.5**	**4.3**



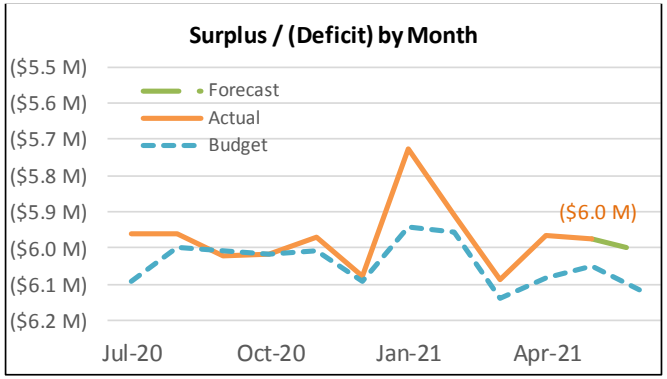


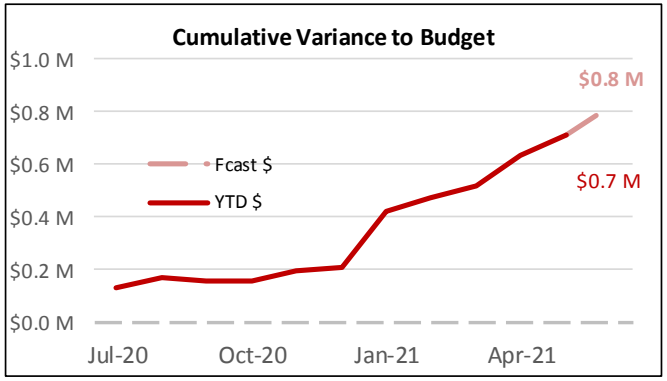


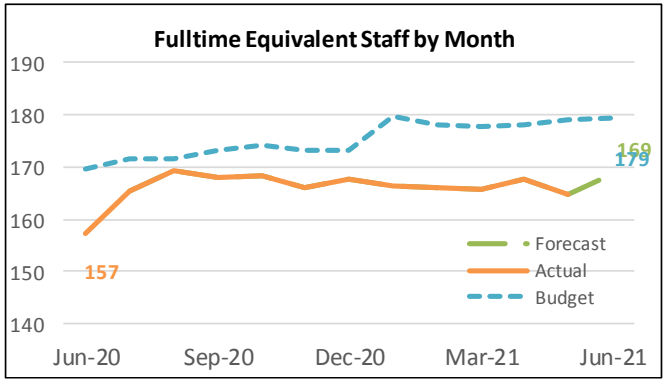
Te Uru Kiriora – Primary, Public and Community Services

$000	May 2021 Actual	May 2021 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Forecast	Year End Variance to Budget
Net Revenue	**736**	**8**	**7,922**	**(66)**	**8,650**	**(66)**
Expenditure						
Personnel	1,141	165	13,383	815	14,637	925
Outsourced Personnel	0	0	7	(4)	8	(4)
Sub -Total Personnel	1,141	165	13,390	811	14,644	921
Other Outsourced Services	65	3	725	25	796	25
Clinical Supplies	350	(119)	2,762	(226)	3,000	(226)
Infrastructure & Non-Clinical	150	19	1,690	145	1,859	143
Total Operating Expenditure	**1,706**	**68**	**18,568**	**756**	**20,299**	**864**
Provider Payments	4,901	(1)	53,893	4	58,793	4
Corporate Services	104	0	1,127	18	1,231	18
Surplus/(Deficit)	**(5,975)**	**75**	**(65,665)**	**712**	**(71,672)**	**820**

FTE						
Medical	3.6	0.2	3.5	0.3	3.5	0.3
Nursing	79.9	4.5	79.9	3.5	80.0	3.5
Allied Health	62.7	7.6	65.3	2.3	65.3	2.5
Support	0.0	0.0	0.0	0.0	0.0	0.0
Management / Admin	18.6	2.1	18.1	2.6	18.2	2.5
Total FTE	**164.8**	**14.4**	**166.9**	**8.6**	**167.0**	**8.8**



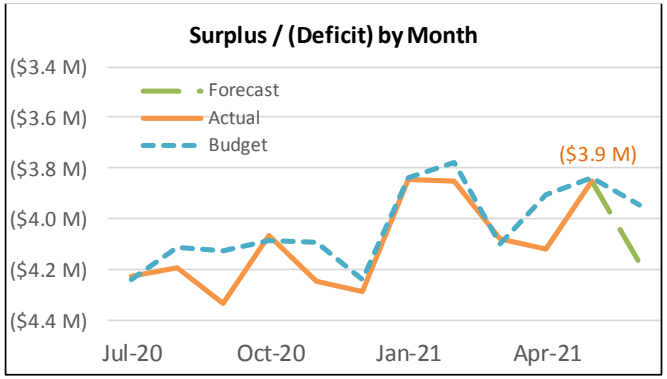


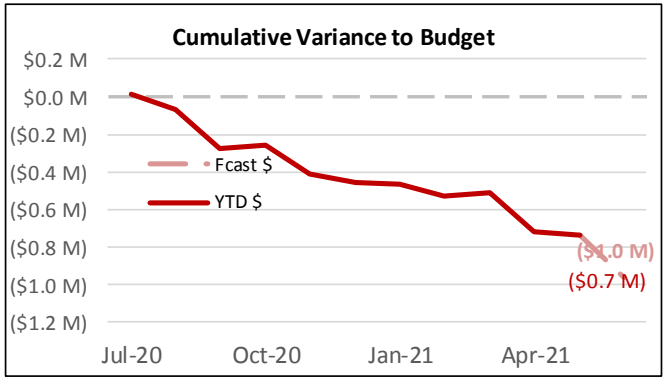


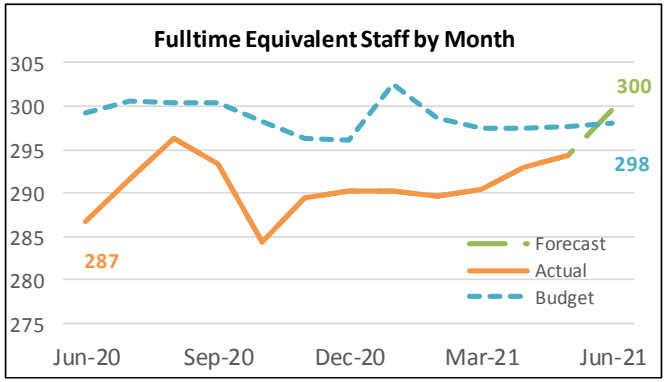
Te Uru Rauhī – Mental Health and Addictions Services

$000	May 2021 Actual	May 2021 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Forecast	Year End Variance to Budget
Net Revenue	**111**	**80**	**473**	**136**	**505**	**136**
Expenditure						
Personnel	2,395	3	25,677	1,799	28,264	1,708
Outsourced Personnel	360	(236)	4,482	(3,123)	4,874	(3,386)
Sub -Total Personnel	2,755	(233)	30,159	(1,324)	33,138	(1,678)
Other Outsourced Services	54	(14)	636	(190)	690	(202)
Clinical Supplies	23	(3)	232	(15)	253	(15)
Infrastructure & Non-Clinical	163	23	1,914	88	2,105	81
Total Operating Expenditure	**2,995**	**(227)**	**32,941**	**(1,440)**	**36,186**	**(1,813)**
Provider Payments	955	135	12,472	569	13,419	712
Corporate Services	14	0	150	0	164	0
Surplus/(Deficit)	**(3,852)**	**(13)**	**(45,090)**	**(735)**	**(49,264)**	**(965)**

FTE						
Medical	17.5	8.7	15.8	10.3	16.3	9.9
Nursing	182.9	(9.4)	186.5	(11.5)	186.6	(11.8)
Allied Health	52.4	3.6	48.2	7.4	48.2	7.4
Support	0.0	0.0	0.0	0.0	0.0	0.0
Management / Admin	41.5	0.4	40.7	1.4	40.9	1.2
Total FTE	**294.3**	**3.3**	**291.2**	**7.5**	**291.9**	**6.8**



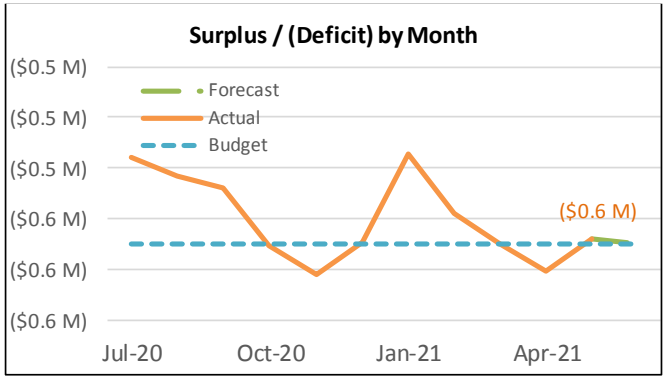


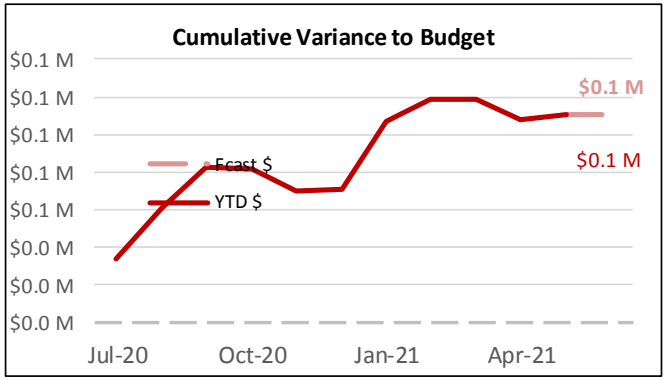


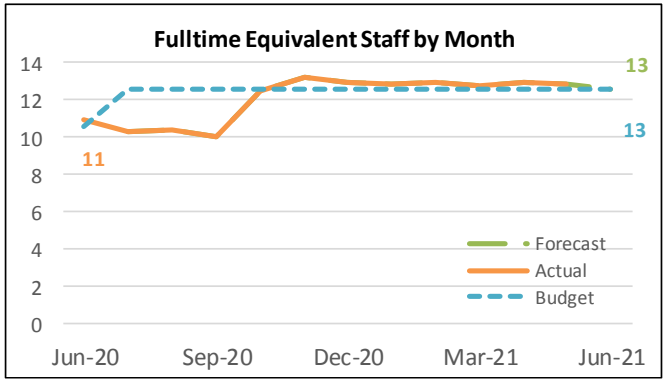
Pae Ora – Paiaka Whaiora Directorate

$000	May 2021 Actual	May 2021 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Forecast	Year End Variance to Budget
Net Revenue	**371**	**251**	**1,580**	**252**	**1,707**	**252**
Expenditure						
Personnel	109	0	1,065	130	1,180	130
Outsourced Personnel	0	0	0	0	0	0
Sub -Total Personnel	109	0	1,065	130	1,180	130
Other Outsourced Services	0	0	0	(0)	0	(0)
Clinical Supplies	0	0	2	0	2	0
Infrastructure & Non-Clinical	10	2	161	(30)	173	(30)
Total Operating Expenditure	**119**	**2**	**1,228**	**100**	**1,354**	**100**
Provider Payments	820	(250)	6,510	(242)	7,080	(242)
Corporate Services	0	0	0	0	0	0
Surplus/(Deficit)	**(567)**	**2**	**(6,158)**	**110**	**(6,728)**	**110**

FTE						
Medical	0.0	1.2	0.2	1.0	0.3	0.9
Nursing	2.0	(0.0)	1.7	0.3	1.7	0.2
Allied Health	4.4	(1.8)	4.0	(1.3)	3.8	(1.2)
Support	0.0	0.0	0.0	0.0	0.0	0.0
Management / Admin	6.5	0.3	6.3	0.5	6.3	0.4
Total FTE	**12.9**	**(0.3)**	**12.2**	**0.4**	**12.2**	**0.4**



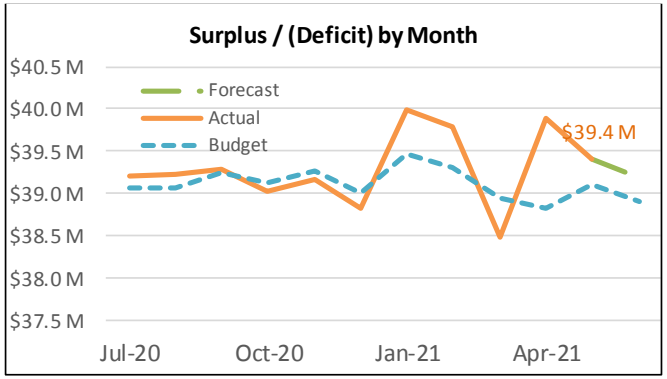


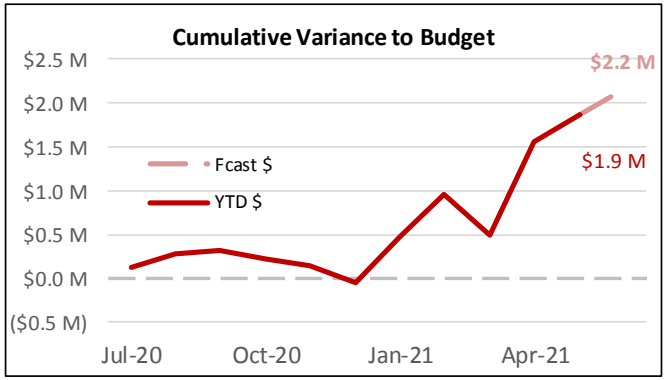


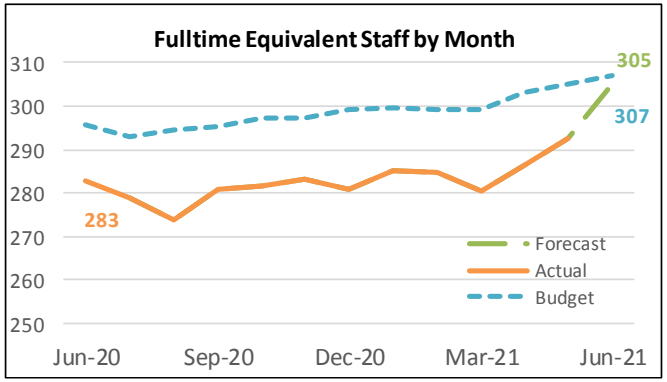
Corporate and Professional Services

$000	May 2021 Actual	May 2021 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Forecast	Year End Variance to Budget
Net Revenue	**57,770**	**1,385**	**624,264**	**4,055**	**680,536**	**3,940**
Expenditure						
Personnel	2,818	(308)	27,537	383	30,377	220
Outsourced Personnel	238	(182)	1,447	(838)	1,518	(851)
Sub -Total Personnel	3,056	(490)	28,985	(455)	31,895	(631)
Other Outsourced Services	178	(5)	1,960	(62)	2,133	(62)
Clinical Supplies	89	(12)	926	(85)	1,004	(85)
Infrastructure & Non-Clinical	5,015	(291)	50,552	717	55,461	556
Total Operating Expenditure	**8,338**	**(800)**	**82,423**	**115**	**90,494**	**(223)**
Provider Payments	11,398	(279)	124,609	(2,306)	134,986	(1,564)
Corporate Services	(1,372)	0	(15,090)	0	(16,462)	0
Surplus/(Deficit)	**39,406**	**306**	**432,322**	**1,864**	**471,519**	**2,153**

FTE						
Medical	14.3	(3.8)	9.4	0.8	9.4	0.9
Nursing	43.6	(0.7)	44.8	(2.9)	44.7	(2.7)
Allied Health	6.7	(1.1)	5.3	0.3	5.3	0.3
Support	13.2	0.1	13.1	0.2	13.1	0.2
Management / Admin	214.8	18.0	209.9	17.4	212.0	16.0
Total FTE	**292.6**	**12.5**	**282.6**	**15.9**	**284.5**	**14.7**





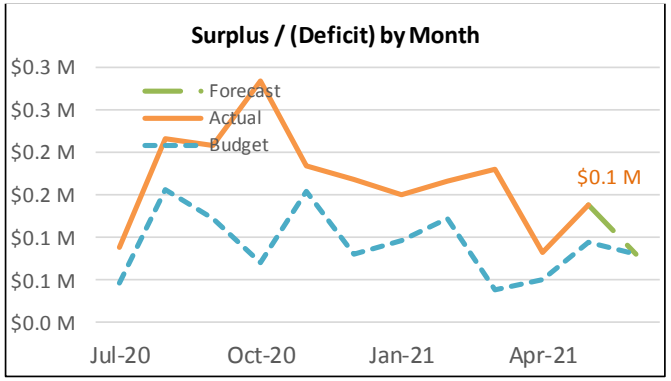


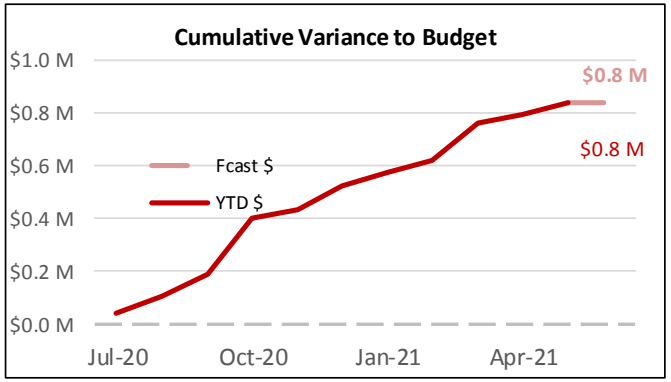
BOARD REPORT

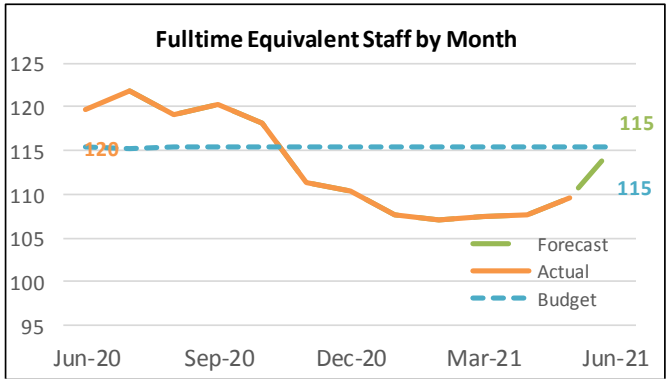
Enable New Zealand

$000	May 2021 Actual	May 2021 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Forecast	Year End Variance to Budget
Net Revenue	**3,818**	**824**	**35,798**	**2,858**	**38,792**	**2,858**
Expenditure						
Personnel	643	93	7,980	356	8,751	356
Outsourced Personnel	41	(15)	344	(47)	371	(47)
Sub -Total Personnel	684	78	8,324	309	9,122	309
Other Outsourced Services	2	7	43	51	52	51
Clinical Supplies	6	(0)	64	0	70	0
Infrastructure & Non-Clinical	2,938	(865)	24,950	(2,382)	27,002	(2,382)
Total Operating Expenditure	**3,630**	**(781)**	**33,382**	**(2,021)**	**36,246**	**(2,021)**
Provider Payments	0	0	0	0	0	0
Corporate Services	50	0	550	0	600	0
Surplus/(Deficit)	**138**	**43**	**1,866**	**836**	**1,946**	**836**

FTE						
Medical	0.0	0.0	0.0	0.0	0.0	0.0
Nursing	0.0	0.0	0.0	0.0	0.0	0.0
Allied Health	23.6	7.5	22.1	9.0	22.8	8.3
Support	17.4	(1.4)	17.6	(1.6)	17.5	(1.5)
Management / Admin	68.5	(0.2)	73.0	(4.8)	72.7	(4.4)
Total FTE	**109.5**	**5.9**	**112.7**	**2.6**	**113.0**	**2.4**







Holidays Act

$000	May 2021 Actual	May 2021 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Forecast	Year End Variance to Budget	Life to date Actual Since May 2010
Expenditure							
Personnel	122	(122)	1,396	(1,396)	36,514	(36,514)	12,393
Outsourced Personnel	130	(130)	470	(470)	623	(623)	470
Sub -Total Personnel	253	(253)	1,867	(1,867)	37,137	(37,137)	12,864
Infrastructure & Non-Clinical	109	(109)	1,112	(1,112)	1,212	(1,212)	1,112
Total Operating Expenditure	**362**	**(362)**	**2,978**	**(2,978)**	**38,349**	**(38,349)**	**13,975**
Surplus/(Deficit)	**(362)**	**(362)**	**(2,978)**	**(2,978)**	**(38,349)**	**(38,349)**	**(13,975)**

COVID-19

$000	May 2021 Actual	May 2021 Variance to Budget	Year to date Actual	Year to date Variance to Budget	Year End Forecast	Year End Variance to Budget	Life to date Actual Since March 2020
Net Revenue	**492**	**492**	**3,531**	**3,531**	**3,734**	**3,734**	**4,240**
Expenditure							
Personnel	206	(206)	1,048	(1,048)	1,133	(1,133)	4,258
Outsourced Personnel	4	(4)	128	(128)	146	(146)	198
Sub -Total Personnel	210	(210)	1,176	(1,176)	1,279	(1,279)	4,456
Other Outsourced Services	147	(147)	1,555	(1,555)	1,601	(1,601)	2,434
Clinical Supplies	14	(14)	71	(71)	78	(78)	415
Infrastructure & Non-Clinical	122	(122)	828	(828)	875	(875)	2,822
Total Operating Expenditure	**492**	**(492)**	**3,631**	**(3,631)**	**3,834**	**(3,834)**	**10,126**
Surplus/(Deficit)	**(0)**	**(0)**	**(100)**	**(100)**	**(100)**	**(100)**	**(5,886)**

APPENDIX TWO – CAPITAL EXPENDITURE

($000)		Budget	Year to Date Approvals	Year to Date Expenditure	Remaining Approved Expenditure	Remaining Unapproved Budget Available	Year End Expenditure Forecast	Forecast Variance to budget
Board Approvals								
SPIRE Project	Infrastructure, Clinical Equipment, IT	9,266	9,038	2,648	6,390	0	4,312	4,954
Mental Health Redevelopment	Infrastructure, Clinical Equipment, IT	8,290	8,186	110	8,076	0	585	7,705
EDOA / MAPU PODS	Infrastructure, Clinical Equipment, IT	4,000	6,000	209	5,791	0	302	3,698
Sub Station Project	Infrastructure	2,281	2,281	1,678	603	0	1,727	554
Acute Services Block	Infrastructure Planning	700	700	0	700	0	0	700
Linear Accelerator Replacement	Clinical Equipment	4,344	4,344	3,504	840	0	4,302	42
Fluoroscopy	Clinical Equipment	1,540	1,640	0	1,640	0	400	1,140
Clinical-Monitors	Clinical Equipment	1,100	88	90	(2)	1,012	90	1,010
Laparoscopic Equipment	Clinical Equipment	670	670	91	579	0	670	0
RHIP	Information Technology	1,623	1,623	933	690	0	1,254	369
RiskMan	Information Technology	1,097	0	0	0	1,097	0	1,097
Programme of Change Mental Health & Addictions	Information Technology & Furniture and Fittings (Approval $2.802k split 20/21 $0.89m & 21/22 $1.905m)	897	897	44	853	0	250	647
Health System Catalogue	Information Technology	600	1,031	421	610	0	487	113
TOTAL Board Approvals		**36,408**	**36,498**	**9,728**	**26,770**	**2,109**	**14,379**	**22,029**
Management Approvals - Specific Items								
Medical Imaging Equipment - Various	Clinical Equipment	500	0	0	0	500	300	200
Anaesthetic Machines & Monitor Replacement	Clinical Equipment	360	0	0	0	360	0	360
Fundus Camera & Microscope	Clinical Equipment	350	242	0	242	108	50	300
Cardiograph Image Vault	Clinical Equipment	250	0	0	0	250	0	250
Decarbonisation Project	Infrastructure	414	414	213	201	0	414	0
Children's Pressure Room	Infrastructure	400	0	0	0	400	0	400
Front Door Project	Infrastructure	314	150	126	24	0	126	188
Digital Workplace Programme	Information Technology	1,850	1188	1,176	12	0	1,418	432
Integration Strategy Implementation (IPaaS)	Information Technology	850	0	0	0	850	250	600
Planned Care - Scope	Information Technology	596	0	0	0	596	0	596
eReferrals (Triage)	Information Technology	585	0	0	0	585	50	535
Digitisation of Clinical Records	Information Technology	452	0	0	0	452	50	402
Website Upgrade	Information Technology	425	0	0	0	425	0	425
WebPASaaS Design & Implementation	Information Technology	400	16	0	16	384	0	400
ICU Clinical Equipment funded by MoH	Clinical Equipment	0	690	690	0	0	690	(690)
Theatre Clinical Equipment funded by MoH	Clinical Equipment	0	52	52	0	0	52	(52)
Covid Testing Van	Vehicles	0	195	0	195	0	195	(195)
Planned Care - Production Planning	Information Technology/Clinical Equipment	300	0	0	0	300		300
Management Approvals - Specific Items		**8,046**	**2,947**	**2,257**	**690**	**5,210**	**3,595**	**4,451**
Management Approvals - Pooled Items								
Clinical & Other Equipment	Clinical Equipment	2,790	1,892	1,423	469	1,157	1,833	957
Facilities & Infrastructure	Infrastructure	4,159	2,111	1,023	1,088	48	1,150	3,009
Information Technology	Information Technology	1,583	2,776	2,742	34	0	2,945	(1,362)
Covid-19	Various	714	936	906	30	0	906	(192)
Enable NZ	Various	1,000	28	28	0	972	150	850
Management Approvals - Pooled Items		**10,246**	**7,743**	**6,122**	**1,621**	**2,177**	**6,984**	**3,262**
TOTAL Against 2020/21 Capex Plan		**54,700**	**47,188**	**18,107**	**29,081**	**9,496**	**24,958**	**29,742**
Approvals against Prior Year Capex Plans			4,511	2,177	2,334	0	2,334	2,177
TOTAL		**54,700**	**51,699**	**20,284**	**31,415**	**9,496**	**27,292**	**31,919**
20/21 Budgeted Depreciation		24,053						
Capital Funding Support		24,538						
		48,591						

BOARD REPORT

For:

X	Approval
	Endorsement
	Noting

Key questions the Board should consider in reviewing this paper:

- Is the progress with the Sustainability Plan satisfactory?
- Is the Board satisfied with progress to date in the delivery of the sustainability savings plan?

To	Board
Author	Judith Catherwood, General Manager, Quality and Innovation
Endorsed by	Finance, Risk and Audit Committee Kathryn Cook, Chief Executive
Date	30 July 2021
Subject	**Sustainability Plan**

RECOMMENDATION

It is recommended that the Board:

- **note** the Finance, Risk and Audit Committee endorsed this report at its July meeting for the Board's consideration
- **note** the progress in the implementation of the Sustainability Plan
- **approve** the Year One benefits reconciliation indicating year to date cash releasing savings of $246,323 have been achieved.

Strategic Alignment

The report supports the MidCentral District Health Board's (MDHB) strategy and key enablers 'Stewardship' and 'Innovation'. The Sustainability Plan supports the MDHB to become more sustainable through change to models of care, systems and processes. This ensures best use of resources to meet the healthcare needs and wellbeing of the population in the MDHB region.

1. PURPOSE

To outline progress in the delivery of the Sustainability Plan for 2020-2023 which was originally approved by the Board in August 2020. A refreshed plan for 2021-23 was approved by the Board in July 2021.

2. SUSTAINABILITY PLAN STATUS UPDATE

The Sustainability Plan is a three-year plan which outlines the approach MDHB will take to ensure the delivery of enhanced services and financial sustainability. The plan is aligned to the sustainability component of the MDHB's Annual Plan. The Sustainability Plan, including a summary of progress is included as Appendix One.

A benefits reconciliation has been completed including the year to date savings delivered against the plan. This is provided as Appendix Two. The savings include cash and non-cash releasing savings. A benefits reconciliation monitoring framework is being put in place to ensure benefits can be reviewed continuously, on a month to month basis, and reported to the Organisational Leadership Team (OLT), Finance, Risk and Audit Committee and the Board. The full benefits reconciliation monitoring framework is expected to be reported at the September meeting.

The Sustainability Plan reporting format has been refreshed. Several initiatives have dedicated funding from the Ministry of Health (the Ministry) and are included in the report for monitoring purposes only. Reports on these initiatives are also provided to the Ministry.

MDHB resources are targeted at the other initiatives. This is consistent with the plan approved by the Board.

Seven initiatives have been completed or progressed to a business as usual status. These initiatives will no longer be reported.

One initiative is incomplete and closed. This is consistent with the decision taken by the Board to pause further delivery of the Te Awa strategy.

OLT has reviewed the plan and the commitments. OLT remain confident the remaining activities can be delivered over the course of the three-year planning period and that total cash releasing savings of a minimum of $4.7 million are achievable.

3. YEAR ONE BENFITS AND SAVINGS

The Year One benefits reconciliation is nearing completion. The year to date position is shown in Appendix Two. The Year One net benefits across the entire programme are as follows.

Year to date cash releasing savings	Year to date target	Percent to target
$0.246 million	$1.15 million	21 percent

There have been delays in implementing several initiatives over the 2020/21 year, which have impacted the delivery of savings. Management has refreshed the savings schedule to take account of the progress against the initiatives to date.

Some areas of the plan have delivered savings above expectations. Overall, the total cash releasing savings across the plan remain consistent with the original plan approved by the Board.

The Sustainability Plan is expected to achieve $4.7 million in cash releasing savings over the three years to 2023. Initiatives that are behind schedule at present will be delivered in the 2021-2023 period. Additional non-cash releasing benefits are also expected each year. Year Two savings are forecast to be $2.1 million. Year Three savings are forecast to be $2.15 million.

Appendices

Appendix One Sustainability Plan 2020-2023
Appendix Two Sustainability Plan Year One Benefits Reconciliation

Appendix One – Sustainability Plan 2020-2023

Service Improvement

Initiative	Overview	Owner	Stage	MoH funded	RAG	Key Progress / updates	Plan over next reporting period	Expected Benefits	Target Completion
Mental Health – community model of care	Design and implement a new community model of care as our response to the Inquiry	Scott Ambridge	Implementation			Decision document released	Implementation of revised model underway	Improved access, safety, experience, choice, staff wellbeing, self-cares / resilience, reduced inequity for Māori, whanau focused models	Q4 2021/22
OPAL community service	Implement the OPAL community service across the district	Syed Zaman	Business Case			Business case drafted, awaiting FY21/22 budget confirmation	Business case to be presented to FRAC/Board	Reduced LOS, bed occupancy, presentations, improved experience	Q4 2021/22
Long Term Conditions	Implement improved pathways of care	Deborah Davies	Implementation			Improved pathways of care underway in Horowhenua	Implemented has been embedded as business as usual	Improved outcomes, experience, reduced inequity for Māori	Complete (BAU)
Primary Care health pathways	Implement a programme of primary care health pathways	Deborah Davies	Implementation			Project ahead of schedule with positive budget variance	Implementation has been embedded as business as usual	Reduced clinical risk / variation, improved experience, reduced inequity for Māori, improved ESPI performance	Complete (BAU)
Hospital health pathways	Implement a programme of hospital health pathways	Lyn Horgan	Implementation	✓		10 clinicians identified as editors with training about to commence	Implementation will continue as part of business as usual		Complete (BAU)
Enhanced stewardship of blood	Effective and efficient use of blood and blood products	Claire Hardie	Monitoring			Blood usage has increased due to increase case mix. Wastage under continual review.	Ongoing management and monitoring via clinical governance committee	Reduced blood wastage	Complete (BAU)
Horowhenua clinical service plan	Design and plan future clinical services for the locality	Chiquita Hansen	Implementation	✓		Service planning expertise confirmed, and planning work has commenced	Planning work continues	Plan to support increasing community health needs in place	Q2 2021/22
Outpatient admin redesign	Review and redesign outpatient administration service model	Judith Catherwood	Scoping	✓		Design expertise secured. Discussion to be held with MALT prior to planning next steps	Benchmarking and design work to commence	Improved experience, safety, reduced services not engaged	Q4 2021/22
Outpatient e-referral/triage	Implement electronic referrals and triage across the enterprise	Lyn Horgan	Business case			Business case drafted and reviewed by the MoH.	Finalise business case for FRAC/Board approval.	Improved ESPI compliance, improved patient safety, improved clinician satisfaction	Q4 2021/22
Outpatient e – transcription and digital mail	Implement voice recognition tools and digital mailhouse	Lyn Horgan	Business case			Business case drafted and reviewed by the MoH. Pilot underway of voice recognition software	Finalise business case for FRAC/Board approval.	Reduced expenditure and FTE, rapid electronic communications, improved clinician satisfaction	Q4 2021/22
Outpatient Navigation co-design	Co-design a model of navigation support to enable improved access to outpatient services	Judith Catherwood	Scoping	✓		Design expertise secured. Discussion to be held with MALT prior to planning next steps	Research and design work to commence	Improved access, safety, outcomes, reduced inequity for Māori and others, reduced services not engaged	Q2 2021/22
Telehealth	Implement telehealth models of care across speciality services	Claire Hardie	Implementation	✓		Implementation underway across several specialities	Procure technical equipment to support expansion	Improved access, experience, convenience, safety and reduced travel for consumers	Q4 2021/22
Ultrasound capex	Procure additional ultrasound equipment to enhance service provision	Lyn Horgan	Complete	✓		Procurement completed	N/A	Enhanced capacity and access to services	Complete
Community infusion service	Develop a model of care to support our community in receiving services closer to home	Lyn Horgan	Implementation	✓		Progressing model of care and capex Progressing planning for pilot sites	Pilot service model underway	Improved access to services, improved experience, improved facility utilisation	Q2 2021/22
Production planning	Enhance production planning expertise and capacity to support service delivery and budgeting approach	Darryl Ratana	Implementation	✓		Recruitment underway. Planning for elective services and winter acute needs has been delivered	Recruit to vacancy to enable extension of production planning across the enterprise	Improved accuracy of budget planning to support effective service delivery in elective and acute services	Q2 2021/22
Gynaecology OP / community procedures	Develop a model of care to support delivery of services in community settings	Sarah Fenwick	Implementation	✓		Discussion with MoH to align alternative project scope due to clinical vacancies	Implement new approach given challenges due to vacancies	Improved access to services, improved facility utilisation, improved experience, reduced inequity for Māori, reduced services not engaged	Q2 2021/22

RAG Key: **RED**: Significant Issues – the timelines and budget will be impacted **AMBER:** Some Issues – chance of impact on timelines and budget **GREEN:** On Track – no issues expected to impact on timelines or budget

Workforce

Initiative	Overview	Owner	Stage	MoH funded	RAG	Key Progress / updates	Plan over next reporting period	Expected Benefits	Target Completion
FTE management	Develop an organisation wide establishment and structured approval system	Keyur Anjaria	Complete			Establishment in place. Approval of change system being established by end of July.	N/A	Reduced FTE growth	Completed
Skill mix	Review clinical workforce mix across all clinical services	Celina Eves	Implementation			Review underway in Te Uru Arotau.	Commence additional service reviews as per schedule	Reduced cost per bed day, reduced cost per CWD and reduced cost per FTE	Q4 2021/22
Reduce dependency on one to one nurse specialing	Improving ordering and clinical practices to support quality care and reduction in use of specialing	Celina Eves	Implementation			Full action plan underway and monitored by Nursing Leadership	Complete benefits tracking system and implement new ordering/approval approach	Reduced use of outsourced specialing expenditure	Q2 2021/22
Workforce Wellbeing	Implement workforce wellbeing initiatives to support all workforce groups	Keyur Anjaria	Implementation			Bradford score reporting underway. Wellbeing Index implementation plan in progress. Education for people leaders underway	Further progress training. Implement the wellbeing index and other wellbeing supports.	Improved workforce wellbeing, reduced sick leave, improved engagement	Q4 2021/22

Savings and Revenue

Initiative	Overview	Owner	Stage	MoH funded	RAG	Key Progress / updates	Plan over next reporting period	Expected Benefits	Target Completion
Equipment Library	Implement a central hospital equipment library	Neil Wanden	Scoping			Project team has been mobilised to plan the project	Project plan to be completed	Reduce expenditure, improved access to equipment, improved space utilisation	Q3 2021/22
Short-term loan equipment	Implement new procurement and distribution pathways for community equipment	Gabrielle Scott	Implementation			Proof of concept commenced. Delayed start may impact benefit realisation	Monitor benefits and consumer experience.	Reduced expenditure, improved consumer and staff experience	Q2 2021/22
Clinical documentation and coding	Clinical documentation, coding and CWD capture	Lyn Horgan	Implementation			Procurement of PICQ tool behind schedule. Revised discharge support approach underway	Implement the PICQ tool and measure impact of education and tools	Increased revenue, improved documentation and patient safety, improved relative stay index	Q1 2021/22
Fleet consolidation	Procure and implement new fleet	Neil Wanden	Complete			Procurement complete and new fleet being implemented	N/A	Reduced expenditure	Complete

Digital

Initiative	Overview	Owner	Stage	MoH funded	RAG	Key Progress / updates	Plan over next reporting period	Expected Benefits	Target Completion
Digitisation of Clinical Records	Implement a digital scanned clinical record	Neil Wanden	Implementation			Business case approved and implementation in progress	Continue implementation plan	Reduced FTE and expenditure on storage Improved clinical and administrative team satisfaction	Q4 2021/22
Digitisation of Corporate records	Implement office 365 and upgraded SharePoint across the enterprise	Steve Miller	Closed			Board have agreed to put Te Awa on hold due to impact of health reform, resourcing, and budget impact	N/A	Reduced duplication of records, improved record management, cost of digital storage and improved productivity	Closed and removed from plan
E – leave management	Implement an electronic leave approval and capture system	Keyur Anjaria	Scoping			Requirements and solutions identified	Confirm solution and progress business case/implementation plan	Improve leave capture, reduced paper	Q2 2021/22
E - Recruitment System	Implement electronic recruitment system for all workforce groups	Keyur Anjaria	Procurement			Progressing as a regional initiative. Vendor identified	Implementation of new solution	Reduction in time to recruit, reduction in paper, improved onboarding, improved productivity of people leaders	Q2 2021/22
ScOPe	Audit and theatre management tool	Lyn Horgan	Implementation	✓		Clinical leadership, funding and project team in place to progress initiative	Implementation planning commences	Improved clinician satisfaction, improved theatre utilisation, improved safety and clinical outcomes	Q2 2021/22

RAG Key: **RED**: Significant Issues – the timelines and budget will be impacted **AMBER:** Some Issues – chance of impact on timelines and budget **GREEN:** On Track – no issues expected to impact on timelines or budget

Appendix Two – Sustainability Year One Benefits Reconciliation

					May 21 YTD Activity			May 21 YTD $		
Activity	Project name	Measure	Cash Releasing	RAG	Baseline (May 20 YTD)	Actual	% to Baseline	Target Savings	Actual Savings	% to Target
Service Improvement	Mental Health Community Models of Care - STAR PN Realignment	Cost of Star 1 & 2	✓					$200,000	$286,535	143%
	Mental Health Community Models of Care - FACT		✓					$600,000	$0	0%
	Enhanced Stewardship of Blood	Units of Blood Wastage	✓		138	175	0%	$100,000	-$12,547	-13%
Workforce and Productivity Improvement	Reducing dependency on one to one nurse specialing	Outsourced Specialing Hours	✓		24,829	24,022	3%	$0	-$102,914	
		Internal Specialing Hours			317,891	330,741	-4%	$0	-$385,515	
Savings and Revenue	Fleet Consolidation and management	Fleet spend	✓					$50,000	$75,249	150%
	Short Term Loan Equipment Management	Equipment spend	✓					$100,000		
	Clinical documentation, coding and case weight capture	CWD per discharge	✓		1.2	1.3	5%	$100,000		

Cash Releasing Total	$1,150,000	$246,323	21%
Non Cash Releasing Total	$0	-$385,515	
Total	$1,150,000	-$139,191	-12%

Measure	Calculation Methodology
Cost of Star 1 & 2	Nursing cost of Star 1 & 2 YTD compared to previous YTD
Cost of Blood Wastage	Dollar value of blood wastage YTD compared to previous YTD
Outsourced Specialing	Total cost of outsourced specialing YTD compared to previous YTD
Internal Specialing	Total number of internal specialing hours YTD compared to previous YTD at a cost of $30 per hour
Fleet spend	Total cost of fleet spend YTD compared to previous year YTD
CWD per discharge - $	The average CWD value per discharge YTD compared to previous YTD

BOARD REPORT

For:

	Approval
	Endorsement
X	Noting

Key questions the Board should consider in reviewing this paper:

- Is progress being made as expected?

To	Board
Author	Steve Miller, Chief Digital Officer Clive Martis, Director Digital Services
Endorsed by	Kathryn Cook, Chief Executive
Date	3 August 2021
Subject	**Te Awa Update – Digital Services Work Programme**

RECOMMENDATION

It is recommended that the Board:

- **note** the Digital Services work programme covering planned work through into the 2021/22 financial year
- **note** progress since the last reporting period
- **note** the national and regional activity that may impact the planned work programme.

Strategic Alignment

This report is aligned to the MidCentral District Health Board's (MDHB) digital strategy, Te Awa.

1. PURPOSE

To provide an update on the priority projects to be delivered across various MDHB business owners, reported by Digital Services, and covering the period up to 30 June 2022.

2. BACKGROUND

In 2019, Te Awa was endorsed by the Board, the Central Primary Health Organisation (PHO), Manawhenua Hauora and the Clinical and Consumer Councils. Te Awa is aimed at enabling the delivery of improved healthcare outcomes across key performance areas for the district over a period of five years. The continued development of this work plan is now paused, however prioritised projects from the original Clinical and Digital Modernisation streams of work continue to progress.

3. THE DIGITAL WORK PROGRAMME – MARCH TO JUNE 2021

Appendix One is a summary of the Work Programme for the 2021/22 financial year. Some of the forecast costings for this work programme are indicative estimates, still dependent on further review and ratification by the Data and Digital Information Governance Group (DDIGG) and subject to budget approvals.

Since the last reporting period:

- The successful migration of 1673 email accounts to exchange online (cloud delivered email) has occurred. A further 1664 active emails accounts are attempting to be migrated over the next two to three weeks. Users are being enrolled onto Multi Factor Authentication (MFA) as part of this process.
- A Digital Services update with an overview of the priority projects has been provided to the Staff Forum and was well received. This will be followed up with additional communication through various channels and forums. An update to the Clinical Council took place on 5 August 2021.
- Hiring of contract resources has commenced to rapidly progress the discovery and scoping phases of the clinical priority projects.
- Engagement has commenced with the Ministry of Health's (the Ministry) Sector Investment Team to overview MDHB's priority projects and discuss the various business cases. This is to ensure that, subject to Board approval, any business cases that need to be approved by the Ministry, can be expedited to enable implementation to commence.

In most cases, the focus is on mobilising the various project teams and hiring contracted resources to scope each individual project and complete business cases for appropriate approvals. Governance of all the projects will come under the oversight of the DDIGG, with a common approach to each project's stewardship. Each project will have an executive sponsor who is ultimately accountable for the successful achievement of the benefits expected by the investment.

4. REGIONAL AND NATIONAL

With the health sector reforms, the delivery of new initiatives has been temporarily paused. This will allow an opportunity to merge prioritised MDHB initiatives with national and regional strategies. Throughout, a continuing focus is held on the delivery of key clinical digital enablement programmes.

National

A national workshop on the Digital and Data aspects of the health sector reform has been coordinated by the Department of Prime Minister and Cabinet's Transition Unit and the Ministry of Health. MDHB's Chief Digital Officer and Hawke's Bay DHB's Chief Information Officer represented the central region at the workshop held on 5 August. Key topics included:

- The Transition Unit and Ministry of Health joint work programme for Digital and Data, including key activities, timelines, and governance.
- Participant contribution to the sector-wide view of Digital and Data priority focus areas over three-time horizons (Now, Next, Later).
- Constructive challenge progress and identifying any gaps or risks that may exist in transition planning.
- Review and seek to finalise the Sector Digital and Data Investment framework and the current candidates for national digital and data budget bid support.

This planning process is in support of the Government's health sector changes and may impact the MDHB's work plan for the coming year.

Regional

Strong regional collaboration is occurring to agree the region's top five candidates for sector funding from the 2021/22 Digital and Data budget bid. A regional collaboration framework is being established and transitioning to the Regional Digital Health Services Operating Model has commenced. Recruitment of a Regional Chief Information Security Officer is underway.

Work is also being done on leveraging the region's skills and competencies in certain services areas or domains, for individual and mutual DHB benefit, with consideration of the National Data and Digital transition plan mentioned above.

Appendix One: Digital Work Programme as at 30 July 2021

Clinical/Business Priorities (New Critical Budget 2021/22)

INITIATIVE	OVERVIEW	BUSINESS OWNER	CURRENT STATUS	PROGRESS BY NEXT BOARD MEETING	STAGE	RAG	FINANCIAL	TARGET COMPLETION
eRecruit	Digital platform for the end-to-end recruitment process within MDHB	Keyur Anjaria	Project team identified, business case in development. Project paused awaiting availability of CTAS Pilot in September to evaluate solution	Progress CTAS Pilot establishment	Initial Scoping	On Track	MDHB Budget TBC as part of business case	Q2 FY21-22
eTriage	Electronic triage of referrals across outpatients and Allied Health	Lyn Horgan	$122k approved for pilot with two specialities within the Allied Health to confirm project implementation approach. Business case in review	Deliver business case for appropriate approval	Initial Scoping	Scope, Timeline & budgets yet to be determined	Further MDHB Budget TBC as part of business case	Q3 FY21-22
Digitising Outpatient Communications	Digitise the process for creating and distributing clinical letters, mail house and digital transcription	Lyn Horgan	Business case in review	Deliver business case for appropriate approval	Initial Scoping	Scope, Timeline & budgets yet to be determined	MDHB Budget TBC as part of business case	Q3 FY21-22
eReferrals	Electronic receiving of referrals across outpatients and Allied Health	Lyn Horgan	Project team identified, business case in development	Deliver business case for appropriate approval	Initial Scoping	Scope, Timeline & budgets yet to be determined	MDHB Budget TBC as part of business case	Q4 FY21-22
Computer Physician Order Entry (CPOE)	Electronic Order Entry and Results Sign Off	Lyn Horgan	Project team identified and commencing implementation planning to develop business case	Project team in place and implementation planning commenced	Initial Scoping	Scope, Timeline & budgets yet to be determined	MDHB Budget TBC as part of business case	Q4 FY21-22
Electronic Prescribing and Administration	Electronic and administrative system for the prescribing of medications to inpatients and the accurate availability of information to Clinicians around current prescriptions	Lorraine Welman	Implementation Planning Study Completed, Project Definition Report under review. Business case to be developed.	Mobilise project team to scope project and complete business case for appropriate approval	Initial Scoping	Scope, Timeline & budgets yet to be determined	MDHB Budget TBC as part of business case	Q4 FY21-22

RAG Key:

RED: Significant Issues – the timelines and budget will definitely be impacted	**AMBER:** Some Issues – chance of impact on timelines and budget	**GREEN:** On Track – no issues expected to impact on timelines or budget

Stage:

SCOPING	BC ARROVAL	INITIATION	IMPLEMENTATION	COMPLETED

Clinical/Business Priorities (New Critical Budget 2021/22) - continued

INITIATIVE	OVERVIEW	BUSINESS OWNER	CURRENT STATUS	PROGRESS BY NEXT BOARD MEETING	STAGE	RAG	FINANCIAL	TARGET COMPLETION
Mosiaq as a Service	Upgrade of the Oncology Information System which supports Regional Cancer Treatment Service in the delivery of radiation therapy and systemic therapy treatment for cancer patients	Sarah Fenwick	Project team being identified with business case to developed	Deliver business case for appropriate approval	Initial Scoping		MDHB Budget TBC as part of business case	Q3 FY21-22
Echo Imaging Vault	Replacement/Upgrade of aged and at capacity, Cardiology Echo Image Vault system (EIV)	Lyn Horgan	Business case approved and procurement exemption approved	Mobilise project team and initiate project activity	Initiation	On Track	$1.7m Board approved	Q2 FY21-22
Digitisation of Clinical Records	The electronic retrieval of patient notes and records	Neil Wanden	Business case approved	Project initiated.	Initiation	On Track	$300k CEO approved	Q3 FY21-22
Surgical Audit	Theatre management and surgical audit system (SCOPE)	Lyn Horgan	Project team has been assembled; Vendor workshop scheduled for project kick off.	Implementation Planning workshop/s to be scheduled and completed	Initiation	On Track	MoH funded	Q3 FY21-22
Connected Care	Mental Health shared care record to support new model of care.	Scott Ambridge	Preferred supplier chosen, vendor negotiation and technical specifications being prepared	Project Initiation plan finalised and approved	Initiation	Scope, Timeline & budgets yet to be determined	$1.26m Board approved	Q4 FY21-22

RAG Key:

RED: Significant Issues – the timelines and budget will definitely be impacted	**AMBER:** Some Issues – chance of impact on timelines and budget	**GREEN:** On Track – no issues expected to impact on timelines or budget

Stage:

SCOPING	BC ARROVAL	INITIATION	IMPLEMENTATION	COMPLETED

Digital Modernisation Priorities (Business as Usual Budget 2021/22)

INITIATIVE	OVERVIEW	BUSINESS OWNER	CURRENT STATUS	PROGRESS BY NEXT BOARD MEETING	STAGE	RAG	FINANCIAL	TARGET COMPLETION
Core Network SAN	Remediation SAN (Storage Area Network) capacity and migrating workloads to Amazon Web Services	Steve Miller	Mobilising tech support and resources to progress procurement and business case. Target completion 10-12 weeks.	Procurement process concluded. Business case drafted	Initial Scoping	FY21-22 Digital BAU budget yet to be approved	Estimated $497k	Q3 FY21-22
Exchange Online (EOL)	Migration on premise exchange to Exchange Online	Steve Miller	Full migration underway	Full DHB user migration by end of Q1 FY21-22 – progressing as planned	Implementation	On Track	$137k Approved	Q1 FY21-22
Zoom Rooms	Zoom Room rollout to support TeleHealth to prioritised business areas	Steve Miller	Zoom 1&2 completed and capitalised. Telehealth project determining locations for Zoom Phase 3.	Zoom Room Phase 3 deployment progressed	Implementation	On Track	$100k Approved	Q2 FY21-22 (8 Rooms)

RAG Key:

RED: Significant Issues – the timelines and budget will definitely be impacted	**AMBER:** Some Issues – chance of impact on timelines and budget	**GREEN:** On Track – no issues expected to impact on timelines or budget

Stage:

SCOPING	BC ARROVAL	INITIATION	IMPLEMENTATION	COMPLETED

BOARD REPORT

For:

X	Approval
	Endorsement
	Noting

To	Board
Author	Keyur Anjaria, General Manager, People and Culture
Endorsed by	Organisational Leadership Team Kathryn Cook, Chief Executive Finance, Risk and Audit Committee
Date	28 July 2021
Subject	**Health, Safety and Wellbeing**

Key questions the Board should consider in reviewing this paper:

- Is the information sufficient to enable the Board to discharge governance responsibilities?
- Does the DHB have a schedule of audits, checks and reviews to ensure that the Health and Safety management systems remain fit-for-purpose?
- Does the DHB have adequate mechanisms to engage its workers effectively?
- Does the DHB have wellness and wellbeing initiatives to promote a healthy workplace culture?

RECOMMENDATION

It is recommended that the Committee:

- **note** the quarterly Health, Safety and Wellbeing report
- **note** that the Health, Safety and Wellbeing report and the Health and Safety Statement were endorsed by the Finance, Risk and Audit Committee at its meeting on 27 July 2021 for submission to the Board
- **approve** the MidCentral District Health Board's Health and Safety Statement.

Strategic Alignment

This report is aligned to the Organisational Strategy and legislative requirements related to governance of health and safety responsibilities for Officers and Directors of a Person Conducting a Business or Undertaking.

1. PURPOSE

To update the Board on activities related to health, safety and wellbeing for the period from 1 April to 30 June 2021. The report and the Health and Safety Statement were endorsed by the Finance, Risk and Audit Committee (FRAC) at its meeting on 27 July, for submission to the Board.

At its July meeting, FRAC acknowledged the increased pressure on hospital services, as a result of higher than usual presentations. A Committee member commented that it was reassuring to note that MidCentral District Health Board (MDHB) was doing well in terms of vacancies and overtime, when compared to other District Health Boards (DHBs). FRAC also noted the increased commentary contained in the report.

The Board Chair advised he had sat in on one session of the Incident Management Team dealing with events from increased pressure on hospital services. He complimented the team involved and noted the efficient process used to deal with issues.

2. BACKGROUND

The Health and Safety at Work Act 2015 sets expectations and defines duties of various roles within every Person Conducting a Business or Undertaking (PCBU). One of these duties requires 'officers' within the PCBU, such as Board members, the Chief Executive and other senior managers who fall within this definition, to exercise due diligence on health and safety (H&S) matters. This includes having a good understanding of key H&S metrics, the key risks of the organisation, and controls which are in place to mitigate such risks. Monitoring these metrics allows officers to ensure that the controls in place are achieving the desired impact.

The DHB's Health, Safety and Wellbeing report is developed on eight key dimensions of a good H&S system as identified in the "*Health and Safety Guide: Good Governance for Directors"*. These dimensions are:

1. Hazard and risk management
2. Incident management
3. Emergency management
4. Injury management
5. Worker engagement
6. Worker participation
7. Working with other organisations
8. Continuous improvement.

The following dashboard provides a visual display of key measures across all these dimensions, showing comparisons against previous periods. Some aspects of the report, especially those relating to breakdown of information by ethnicity, will provide greater insights as the report matures over the next few quarters. Commentary following the dashboard provides further information and analysis on some of these dimensions.

Health and Safety Dashboard - Qtr 4 20/21 (31 Mar - 30 June 21)

Notifiable Incidents
Total reported to WorkSafe

Trend	
0	0

Qtrly Trend

Risks
Proportion reviewed on time

Trend	
0%	100%

Sick Leave Rate
Sick leave hours compared with paid hours

Non - Māori Staff		Māori Staff	
Trend		Trend	
0%	3.6%	0%	4.3%

Reported Staff Incidents

Non - Māori Staff		Māori Staff	
Trend		Trend	
N/A	235	N/A	11
Data not available		Data not available	

Incidents Closed in 30 Days

All staff	
Trend	
0%	100%

Qtrly Trend

Workplace Inspections
Percentage of scheduled

Trend	
8%	78%

Accepted Workplace Claims

Non - Māori Staff		Māori Staff	
Trend		Trend	
8 27%	38	3 150%	5

Top 5 Incident categories

	1	2	3	4	5
Total Incidents	150	229	221	222	246
Exposure	41	27	34	27	35
Impact	12	25	11	11	18
Behaviour	14	55	43	24	40
Musculo-Skeletal	13	20	25	31	35
Falls	20	19	18	9	18

Training attendance rate
Percentage of scheduled

All staff	
Trend	
1%	98%

Qtrly Trend

Health & Safety Committees
Percentage of scheduled

All staff	
Trend	
-2%	83%

Cost of Accepted Claims
($000)

Non - Māori Staff		Māori Staff	
Trend		Trend	
48 122%	86.90	-1 -8%	7.80

Contracts/Tenants Inteface Meetings Held

Yes

Emergency Events/ Response

Yes

Trend Key

- Increase > 5%
- Within 5%
- Decrease > 5%

Trend is based on the same period in the previous year unless otherwise specified.

Description of Staff Incidents:

Exposure/Contact with: either exposure to, or contact with, hand sanitiser, blood, body fluid, radiation, smoke or needle stick injuries.

Behaviour Related - From Patient/Visitor: Behaviour by a Patient or Visitor towards staff/contractors that may include threatening behaviour, abuse, and harassment

Trip, Slip, Fall: Fall From height, slippery surface, stairs, poor lighting, or obstruction etc

Impact/Caught/Struck/Hit by: hit by a patient or other staff, struck by an object or a motor vehicle accident.

Musculo-skeletal - Material/Equipment: lifting, ergonomics, cramped awkward work environment or heavy load.

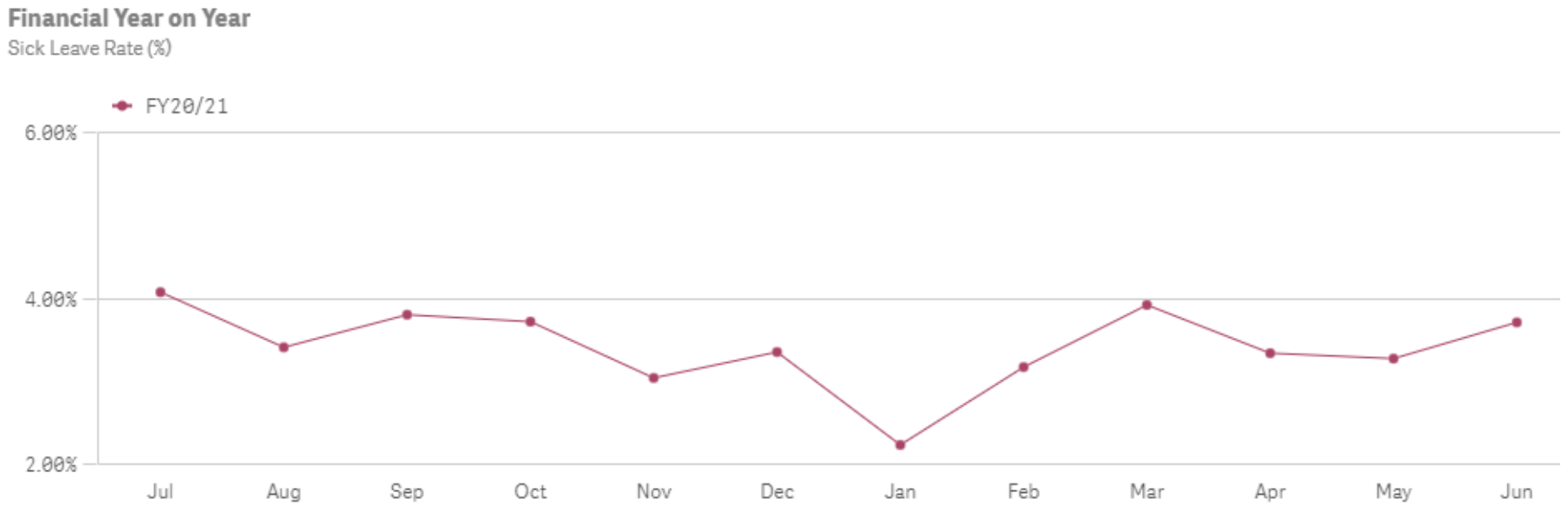
3. INSIGHTS AND COMMENTARY

This report provides key information to members of the Board about health, safety and wellbeing activities which have been undertaken within the DHB for the reported quarter. The report also provides additional information about activities being undertaken to prevent occupational violence in the workplace. Commentary on key aspects of the report are provided below.

- There were no notifiable incidents during the reporting period.
- The number of incidents reported during the quarter have increased to 246 compared to 222 in the previous quarter. This increase is largely related to two categories: 'Behaviour related' (from patients and visitors against staff) and the number of falls. The number of behaviour related incidents have increased from 24 to 40 in this quarter compared to the previous quarter. This has been mainly due to challenging presentations in the STAR 1 Ward. The number of falls which have occurred in this quarter have also increased to 18, from nine in the previous quarter. This increase is attributable to wet weather and shortened periods of daylight. The Occupational Health team continues to convey messages to staff to ensure that they remain careful and vigilant when moving about the campus, especially in early morning and late evening hours.
- There were 43 workplace injury claims in the quarter. This number was up from the 32 reported in the previous quarter. This is consistent with the increase in the number of incidents reported in this quarter. Most of the claims were related to slips and trips (14) followed by musculoskeletal injuries (11). Of these, 11 were moving and handling injuries; three were related to patient moving and handling. The Occupational Health team has an occupational health nurse who has been spending time guiding staff using equipment efficiently to reduce the number of these injuries. Most of the other musculoskeletal injuries were related to sprains and strains caused by twisting, turning and bending in the workplace and were not directly related to patient handling.
- The cost of workplace claims for this quarter has increased to $96k, up from $39k in the previous quarter. This increase is mainly due to a year-end wash-up completed by ACC annually. A year-on-year analysis of the total cost of claims for the DHB's financial year (1 July to 30 June) is provided below. While the number of workplace injuries for the year has not changed significantly, the cost of managing claims has been reducing.

	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21
Number of claims	178	164	142	166
Total cost of claims	$413,005	$461,632	$371,860	$316,361

- The percentage of staff taking sick leave has increased slightly from 3.26 percent to 3.64 percent. The percentage of Māori staff taking sick leave has reduced slightly from 4.66 percent to 4.33 percent. The overall sick leave percentage for the DHB has remained consistent over the year, ending slightly below 4 percent. A graph indicating sick leave for all staff over the 2020/21 year is provided below. No significant professional groups or areas indicate any significant spikes or areas of concern.



- H&S committees continued to meet as scheduled this quarter. The DHB's preparation for the COVID-19 resurgence in the month of June resulted in two of the 18 committee meetings being cancelled. At the time of writing this report, these two committees have held their meetings. The contractor and tenant H&S committee met as scheduled within the reported quarter. Information about fit testing of N95 masks and the process for managing staff matters related to the COVID-19 resurgence and vaccinations were discussed in detail.
- In accordance with requirements outlined in the Health and Safety at Work Act 2015 and the Worker Participation Agreement signed by all unions and the DHB in 2019, MDHB is in the process of completing elections for H&S representatives. This project is progressing as planned and representatives for three committees have been confirmed. Nominations for H&S representatives across six other H&S committees is underway. The election process for H&S representatives across the remaining committees is expected to be completed by the end of March 2022. The delay in completing the elections is because the process will be paused over July, August and September, as the DHB prepares for its annual ACC audit in September 2021.
- The number of completed workplace inspections remains high and continues to increase. Workplace inspections are an important measure to assess existing hazards and risks relevant to a particular work area and identify any new hazards which are identified. Activities to manage existing hazards are verified and any exceptions are reported to the manager of that work area for rectification.
- All H&S enterprise risks which were due for review during the reported quarter, have been reviewed with no significant changes to their residual risk ratings.

- The Principal Risk and Resilience Officer continues to monitor Ministry of Health channels to ensure MDHB's readiness should a COVID-19 resurgence occur.
- A small Incident Management Team was established to respond to any events resulting from the NZNO strike action. Incident Control Points (ICPs) were established in both the Integrated Operations Centre (Palmerston North Hospital) and Horowhenua Health Centre during the strike. There were no significant issues identified by the ICP during the strike action.
- MDHB is required to undertake fit testing of staff who may be required to wear N95 masks while employed in roles which have potential for biological (infection) or chemical (pharmacy) exposure, including exposure to COVID-19. So far, the DHB has been contracting the services of an external agency to carry out this fit testing. Given that this is going to be a regular activity, it is not only prudent and convenient for staff, but also significantly cost effective for the DHB to bring this activity in-house. Suitable staff have been appointed to these roles and the DHB will commence delivering this service to its employees, contracted staff and THINK Hauora on a regular basis from August 2021.
- The DHB continues to deliver education and training to ensure all staff maintain high levels of competence in managing issues related to clinical practice and H&S. Over the reported quarter, the attendance levels at training courses remained high at 98 percent. The table below outlines the training courses which were delivered to staff during the reported quarter. The table also provides information about the delivery mechanism of these courses (face-to-face or online).

Course	Attended	Delivery
Introduction to Health and Safety	125	Online
Laundry Safety	7	Online
Consent	14	Online
Disability Responsiveness	29	Online
Fire and Building Warden	14	Face to Face
Health information and Privacy	6	Online
Incident Reporting	111	Online
Keeping well in the Workplace and Preventing Upper Body Discomfort	4	Face to Face
Orientation (Safe Moving and Handling)	39	Face to Face
Total	**349**	

- As part of the annual plan targets for the 2020/21 year, the expectation was that at least 30 percent of the DHB's frontline staff complete a training programme which allows them to effectively interact with patients who present with a disability. So far 653 frontline staff have completed this training, which equates to almost 26 percent. To increase this number, the training programme has been scheduled every month to ensure that maximum front-line staff get an opportunity to participate.

- The DHB continues to deliver Level 1 training for all its H&S representatives. At the time of writing this report, over 80 percent of the DHB's H&S representatives have completed Level 1 training. The next training session is scheduled for August 2021. This will further increase the number (and percentage) of trained H&S representatives. New H&S representatives will be prioritised for this training.
- The DHB continued to deliver health, safety and wellbeing support to its staff. A team of DHB personnel are trained to respond to staff when they experience a critical incident at work. Critical incident management support was extended on two separate occasions to staff during the reported quarter.
- The Psychosocial Wellbeing Strategy (the Strategy) provides a strategic pathway to support overall staff wellbeing. Following discussion at the July Board meeting, the Strategy will be reworked and will be re-submitted to the Board after it has been endorsed by Manawhenua Hauora.

- The DHB continued to deliver some face-to-face wellness programmes for staff including:
  - Tai Chi classes weekly
  - Pilates weekly
  - Loan bikes, free of charge
  - Meditation
  - Discounted e-bike scheme.
- The DHB has introduced long service awards to value long serving staff members. The first of these award ceremonies was held on 29 April. These awards have received positive feedback and will contribute toward building a desirable organisational culture, where our staff feel valued. Further ceremonies are scheduled to reward and recognise over 1100 or so staff who have qualified for the award.

3.1. Preventing Occupational Violence

The Preventing Occupational Violence Strategy was developed following input from staff and union partners in 2019. The strategy was approved by the Board in December 2019. A steering group oversees the progress of activities identified within the strategy.

A working group comprising a cross-section of DHB staff including nursing, allied health, communications, facilities, risk, medicine, digital services, Human Resources, and union delegates meets regularly to monitor progress and lead various initiatives. A NZNO delegate who has been co-opted onto the working group provides regular updates on progress against actions from this strategy to the Bipartite Action Group.

A report on progress made against various actions was provided to the Board in February 2021. Since that report, the following key activities have been progressed.

- A single lone-worker policy and risk assessment process is being developed. This will be circulated to staff and union partners for feedback.
- A one-page flow chart has been developed, which will be a guide on the support available to staff if they experience violence or aggression at work.
- A trial of duress alarms for staff working in the community (District Nursing and Community Mental Health) is underway. The trial will be undertaken for three months after which and subject to suitability of the devices, a robust procurement process to systematically replace mobile duress alarms will follow.
- The DHB's fleet cars will have GPS monitoring systems fitted, which will allow the vehicles to be monitored. As at the end of March 2021, about 25 percent of the DHB's vehicle fleet had GPS tracking devices installed in them. The device will be useful should staff get stranded, especially when they visit remote locations. As the fleet gets refreshed, all new cars provided to the DHB will have a built-in GPS tracking device.
- A multi-disciplinary working group to investigate and design a Critical Incident Stress Management response has been set up. Members of this group are certified and trained in providing support to staff following a critical incident. The group has already provided support to staff a few times since March 2021. The support was invoked twice during the reported quarter.

3.2. Health and Safety Statement

'Officers' of the DHB are required to review their commitment to H&S, via a statement every three years. This statement is displayed in public spaces across the DHB. The last review of the statement was undertaken in 2018. A draft H&S statement is included as Appendix One. The statement is consistent with the DHB's agreed values and the focus areas of the DHB's People Plan, *He kura te Tangata*. The statement has had Te Reo input from the Pae Ora Paiaka Whaiora Directorate. The statement was endorsed by FRAC and is now provided to the Board for approval.

3.3. Staff shortages and overtime

A comparison of staff overtime at MDHB, against other DHBs, as well as a report of overtime for nursing staff is provided in Appendix Two (the triangles in the graph depict the data point as at the previous quarter). A month-on-month graph trend of overtime in numbers of FTEs, is enclosed as Appendix Three. While MDHB remains low in overtime usage both for nurses as well as all staff when compared nationally, the amount of overtime FTEs for the nursing workforce has increased over the quarter, from 16.08 in May to 18.83 in June. Most the overtime was undertaken in Ward 21. Upon investigation it was found that:

- Most of the overtime was undertaken because the ward has been managing more than its scheduled number of patients. Overtime was required to maintain safe staffing levels.
- Care Capacity Demand Management (CCDM) calculations for Ward 21 are expected to be completed in July and any increase to the FTE allocations, will be recruited to following approval. Recruitment to these vacancies will reduce the amount of overtime within this ward over a period of time.

As at 31 May 2021, MDHB had 32.98 FTE Nursing and Midwifery vacancies and continues to actively recruit to them. The appointment to a dedicated nurse recruiter has been completed and the preferred candidate joined the DHB in late July. This role will focus on filling the current nursing and midwifery vacancy levels which should flow on to reducing these vacancies and overtime for nursing staff.

An Official Information Act response identifying nursing vacancies over the last three years was provided by the Technical Advisory Service based on Health Workforce Information Programme (HWIP) data. This response, indicating MDHB's year-on-year nursing vacancies as compared to the other DHBs is attached as Appendix Four. MDHB's nursing vacancy level is below the national average. The low vacancy levels also corelate with lower levels of nursing and midwifery overtime when compared nationally. Efforts are underway to monitor and investigate overtime levels and further reduce these vacancies, which should reduce work pressures and overtime for nursing and midwifery staff.

3.4. Health and Safety activities planned for the following quarter

With the opening of quarantine-free travel between Australia and New Zealand, the DHB (especially the Occupational Health (OH) team) will continue to support the workforce work stream as required. The following key activities are being planned for the next quarter:

- Members of the OH team continue to deliver in-ward training to staff around the safe and appropriate use of equipment. The training has received good feedback and buy-in and will contribute to the reduction of any patient related musculoskeletal injuries.
- While the project to conduct elections across all H&S committees will be paused as MDHB prepares for its annual ACC audit, the election process which is currently active across some H&S committees, will be concluded.
- The DHB is due for its annual Accident Compensation Corporation audit in September. Work is underway to prepare for this audit.
- Work on the Psychosocial Wellbeing Strategy will continue. Once feedback and support has been secured from Manawhenua Hauora, the Strategy will be provided to the Board.
- A Coaching and Mentoring programme (Wahine Connect), which focuses on supporting female Senior Medical Officers, is currently being trialled. The programme is part of a gender equality action plan developed by the People and Culture team with support from senior medical staff. Once piloted, the programme will be expanded wider across other professional groups.

Appendix One

Health and Safety Statement 2021- 24

Our Culture
Kia ū ki te pai

Inspire our people towards an enhanced culture of Health, Safety and Wellbeing

Ko te tokomaha a Rangi...
Kia kotahi te waihoe kia ū te waka ki uta

Our Ways of Working
Kia pono te mahi

Support work processes that improve efficiencies, reduce risk and enable excellence

Ki tētahi te kaunoti, ki tētahi atu te hika
Mauri mahi, mauri ora

Our Environment
Kia tau te mauri

Design a work environment that delivers an exceptional Health and Safety experience.

He waka kōtuia e kore e tuku ngā mimira

Our Capability
Kia toi te mana

Enable staff to make meaningful contributions to matters of Health and Safety

Ka tū tātou hei pou mō te kupenga

Our Values

Compassion | ***Kia whai aroha***
We will be responsive to needs of our people, whanau and community

Respect | ***Kia whai ngākau***
We will demonstrate appreciation for others and never cause offence

Courage | ***Kia Mātātoa***
We will participate with confidence and enjoyment

Accountable | ***Kia noho haepapa***
We will assume responsibility for our actions in striving for excellence

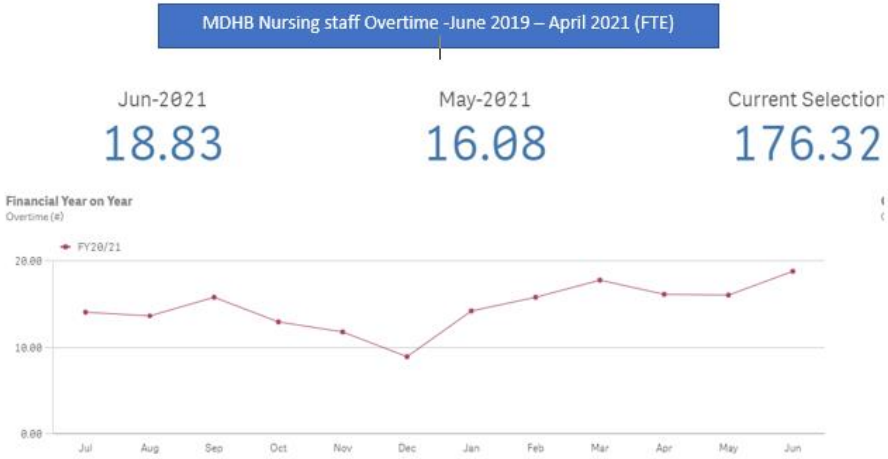
Brendan Duffy
Board Chair

Kathryn Cook
CEO

Date

Appendix Two

Overtime – National and Local comparison



Appendix Three

Index page

Vacancy FTE bar charts

Visualise TAS
Interactive health insights from

Quarter: March 2021

HWIP occupation group: Nursing

ANZSCO unit group: All

ANZSCO description: All

ANZSCO skill level: All

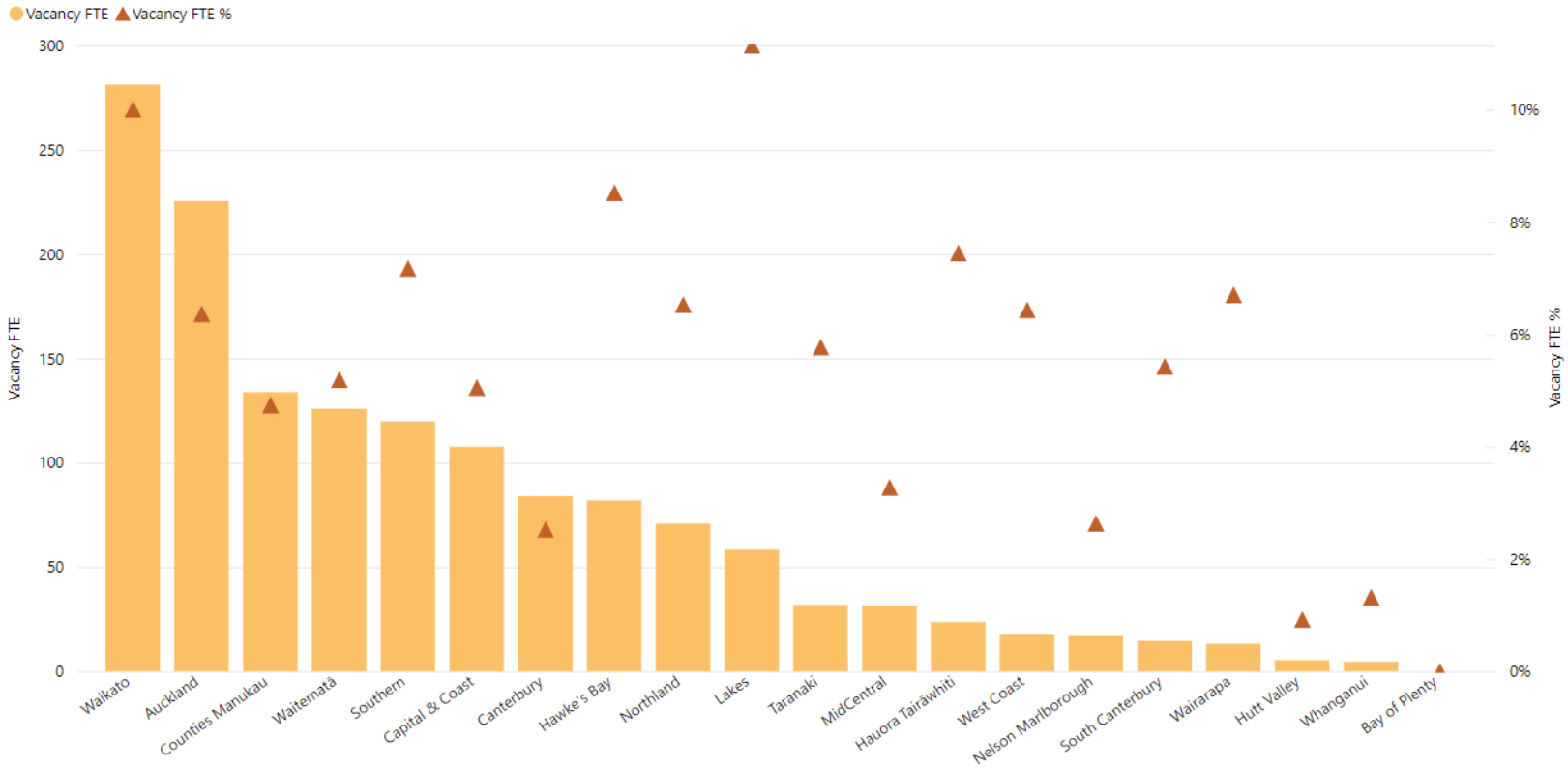
DHB: All

Region: All

DHBSize: All

Choose category: ANZSCO description | ANZSCO unit group | DHB | DHB size | HWIP occupation group | Region

Vacancy FTE(bar chart, left axis) and vacancy FTE %(marker, right axis) - quarter selected : March 2021



Appendix Four

KaiTiaki media query – nursing vacancies

Deadline: Wednesday 30 June 2021

Query *KaiTiaki t*o all DHBs – How many nursing vacancies do you currently have?

Response (to be attributed to DHB spokesperson and sent by TAS).

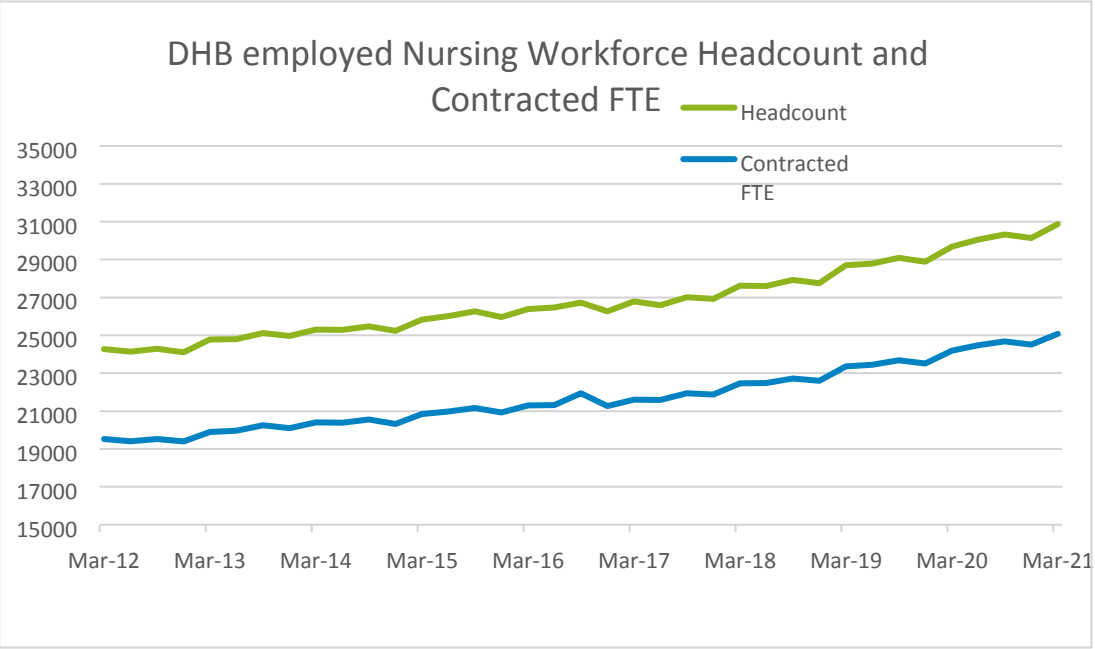
On the following page is a table showing DHB-employed nurse vacancies from 2019 to 2021.

For the sake of comparison, we've provided figures for vacant full-time equivalent (FTE) nursing positions by DHB and the vacancy rate for each DHB and nationally.

The nursing workforce count is based on the Health Workforce Information Programme (HWIP) Nursing occupation group. This includes Registered and Enrolled Nurses, Nurse Practitioners, Nurse Managers, Nurse Educators, Nurse Researchers and Nursing Clinical Directors.

The table shows vacancies on the specific date of 31 March each year and might differ from the monthly statistics provided to NZNO though the Care Capacity Demand Management Programme (CCDM) for more recent months.

The nursing workforce By way of context, the size of the nursing workforce has been increasing steadily as shown in the graph below. Over the three-year period since the last NZNO MECA settlement, the number of nurses in DHBs has increased by over 3,200 (more than 2,600 FTE).



March	FTE value
2012	19,522.93
2013	19,902.42
2014	20,412.32
2015	20,844.25
2016	21,291.67
2017	21,605.54
2018	22,465.93
2019	23,369.60
2020	24,187.80
2021	25,079.60

The statistics you requested

While the total vacancies at the end of March 2021 are greater than at the end of March 2019, the vacancy rate has increased by less than one percentage point which partly reflects the growth in the total workforce.

The vacancy rate is calculated as the number of vacant FTE, divided by the total number of contracted FTE and vacant FTE.

The 2021 figures also include a significant number of COVID-19 Vaccination Programme vacancies that would be in addition to the previous year's total FTE positions.

Where the table is blank, no figures are available for that DHB for that period.

Nursing Vacant FTE and rate by DHB between 31 March 2019 and 31 March 2021

	2019		2020		2021	
	Vacant FTE	**Vacancy Rate**	**Vacant FTE**	**Vacancy Rate**	**Vacant FTE**	**Vacancy Rate**
Auckland	185.86	5.5%	383.04	10.4%	225.33	6.4%
Bay of Plenty	73.57	7.1%	120.80	10.8%		
Canterbury	51.90	1.7%	41.66	1.3%	83.91	2.5%
Capital & Coast	46.31	2.5%	130.50	6.6%	107.68	5.1%
Counties Manukau	223.94	9.0%	117.47	4.6%	133.80	4.7%
Hawke's Bay	38.40	4.6%	63.50	7.2%	81.90	8.5%
Hutt Valley	6.90	1.1%	8.69	1.4%	5.40	0.9%
Lakes	31.10	6.5%	37.15	7.8%	58.30	11.1%
MidCentral	37.90	4.3%	31.30	3.4%	31.60	3.3%
Nelson Marlborough	24.00	3.8%	21.55	3.4%	17.40	2.6%
Northland	54.90	5.7%	49.27	4.9%	70.77	6.5%
South Canterbury	12.44	4.8%	6.50	2.5%	14.60	5.4%

Southern	94.08	5.9%	113.35	7.0%	119.80	7.2%
Tairawhiti	16.20	5.7%	11.30	3.9%	23.60	7.4%
Taranaki	33.70	6.5%	29.74	5.4%	31.85	5.8%
Waikato	160.96	6.2%	94.39	3.7%	281.16	10.0%
Wairarapa					13.20	6.7%
Waitemata	107.45	4.6%	97.99	4.2%	125.79	5.2%
West Coast	7.00	2.6%	16.00	5.6%	18.00	6.4%
Whanganui	11.20	3.1%			4.70	1.3%
All DHBs vacancy	**1217.80**	**5.0%**	**1,374.19**	**5.4%**	**1,448.78**	**5.7%***

**The All DHBs vacancy rate for March 2021 excludes Bay of Plenty, although they are included in the Total Employed Workforce quoted in the table*

Please note:
Total employed workforce data excludes casuals, contractors, and people on parental leave or leave without pay.

The definition of a vacancy for the purposes of the Health Workforce Information Programme (HWIP) collection is as follows:

An unfilled position that has funding allocated and will be actively recruited for within six months.

1. It is a permanent position that is part of the FTE allocation (if applicable).
2. Where a vacancy exists, it remains a vacancy when temporarily filled.

For more information, the Health Workforce Information Programme holds data on the DHB employed workforce providing a national, regional and local picture of the health and disability sector workforce.

Discussion/Decision papers

17 August 2021

Printed from Stellar by
Margaret Bell <margaret.bell@midcentraldhb.govt.nz>

BOARD REPORT

For:

	Approval
	Endorsement
X	Noting

Key questions the Board should consider in reviewing this paper:

- Is the Board satisfied with the progress of the Clinical Council? If not what further advice does it want to provide to the Clinical Council Chair and members?

To	Board
Author	Judith Catherwood, General Manager, Quality and Innovation
Endorsed by	Kathryn Cook, Chief Executive
Date	27 July 2021
Subject	**Clinical Council Report**

RECOMMENDATION

It is recommended the Board:

- **note** the contents of the Clinical Council report.

Strategic Alignment

This report aligns to all four of MidCentral District Health Board's (MDHB) strategic imperatives and provides an overview of progress made to date by the Clinical Council.

Introduction

The Clinical Council was formed in 2017 and reports to the Board. It provides independent strategic advice on district-wide clinical matters to the Board, the Organisational Leadership Team (OLT) and has a role across the District Health Board (DHB) and THINK Hauora. The Chair of the Clinical Council will present the report and take questions from the Board.

Kaunihera Haumanu
Clinical Council

Summary

Clinical Council has continued its focus on equity, mental health, the Te Awa strategy, facilities and population and workforce well-being.

Equity

The Clinical Council remain focused on addressing inequity and understand the effort by many across the MidCentral DHB district to reduce long-standing inequity for Māori and other priority groups. Council also note that despite these efforts, it seems incredibly hard to see change in the impact measures. Council are determined that change will come and there are encouraging signs of progress. Council has a joint hui planned in September with the Consumer Council, to get assurance that we have meaningful engagement and likely positive outcomes in this space. The Clinical Governance model also provides a place where clinical teams can have a focus on how well they are doing in addressing inequities in their service delivery model.

Mental health

The Mental Health Strategy for MDHB is very exciting. Clinical Council were pleased to participate in the recent consultation exercise. We are aware of the significant change process required and of the workforce challenges to switch to a predominantly primary model for mental health. Although consultation has been arguably light, the plan is robust, and the conceptual transformation is very exciting indeed. Council has heard positive news of diminished youth suicide, thought to be largely related to increased funded support in schools.

Digital

Unfortunately, the health reforms mean that the important Te Awa strategy has been put on hold. The Clinical Council expect that this financial year there must be the implementation of e-referrals and e-prescribing within the hospital. Other modest gains may be achieved. Dr Fattah and Tim Dunn are members of the Digital, Data and Informatics Governance Group (DDIGG) and are also members of the Clinical Council. The Council receive regular reports from the group and want to ensure the Board are aware of how critical these digital initiatives are to improved quality of care, workforce retention and sustainability in our district.

Facilities

The issues of inappropriate facilities, space and the mitigation plans, are well understood by the Clinical Council. In addition the Council continue to reconcile the expectations of clinicians with the power of the possible. It is disappointing to see acrimony taking a part in this, but the Clinical Council has observed good efforts to reconcile and is inviting the Combined Medical Staff to their August meeting to continue the discussion.

Leadership team

We have been privileged as a Clinical Council to observe some incredibly hard working and dedicated leaders seeking to progress the MDHB strategy with obvious motivation and commitment. We are always pushed for resource and workforce but this should not stop us striving for excellence and hoping that our transformed health services will attract positively motivated staff, prepared to work in innovative and exciting ways. The leaders we have met with have truly been an inspiration.

Dr Simon Allan
Clinical Council Chair
27 July 2021

BOARD REPORT

For:

	Approval
	Endorsement
X	Noting

Key questions the Board should consider in reviewing this paper:

- Is the Board satisfied with the progress of the Consumer Council? If not what further advice does it want to provide to the Consumer Council Chair and members?

To	Board
Author	Judith Catherwood, General Manager, Quality and Innovation
Endorsed by	Kathryn Cook, Chief Executive
Date	27 July 2021
Subject	**Consumer Council Board Report**

RECOMMENDATION

It is recommended the Board:

- **note** the contents of the Consumer Council report.

Strategic Alignment

This report supports the Consumer Council's strategic imperative to partner with people and whānau to support health and wellbeing.

Introduction

The Consumer Council was formed in 2017 in line with the District Health Board's (DHB) newly developed strategy and to assist the DHB in achieving their purpose of Quality Living, Healthy Lives and Well Communities.

In 2020 MidCentral District Health Board (MDHB) reaffirmed its commitment to resource strategic priorities which address the improvement of health outcomes for Māori, and to implement equitable strategies for other population groups with poor health outcomes. The Consumer Council has aligned its work programme to these strategic priorities.

The Chair of the Consumer Council will present the report and take questions from the Board.

Consumer Council Network

In the last report, the Consumer Council had been considering extending its model with members holding portfolios with specific responsibilities for key communities. The intent of this was to strengthen the voice of these specific priority communities within the Consumer Council and wider consumer representative panel. The model proposed an expanded remit and alternate remuneration system for members. There is a requirement to comply with the Public Services Commission remuneration guidance in all DHBs. As a result, the Consumer Council were unable to pursue the development of a different model based around an honorarium payments for each member.

It was also proposed that members create more substantive links with community networks and groups enabling the voice for people with poor health outcomes. This approach was intended to help identify consumer trends and a pipeline of informed consumers for consumer representative roles. The Consumer Council model instead remains centered on Consumer Council members attending Consumer Council meetings.

Despite this, the Consumer Council remain focused on connecting with specific populations and has strengthened the membership of the Council in recent months to reflect this.

Consumer Council Recruitment

Recruitment to fill the three vacant positions on the Consumer Council began on 13 April 2021. Advertisements for members were widely circulated, via communications contact lists, MDHB social media pages and displayed in the *Manawatu Evening Standard.* Current Consumer Council members were encouraged to forward the advertisement to their contacts in relevant groups.

Applications closed on 30 April 2021 with 12 candidates applying. After a thorough interview process three were selected as new members. Skye Shaddix, Natalie McLean and Christine Elers have joined the Consumer Council and were welcomed to their first meeting in July 2021.

These new members replace Dot Boudelot, Helen Chong and Hilary Humphrey who resigned from the Council. MidCentral DHB and the Consumer Council thank all three for their work and input to the Council during their membership.

Recruitment will soon begin for a new Consumer Council member due to the recent resignation of Kaylene Kani. Kaylene is also thanked for the work and input into the Council during her membership. A focus will be on recruiting a member of the Pacifica Community to fill a gap in that demographic.

The two candidates who were not selected to be part of the Consumer Council were offered the opportunity to be part of the Consumer Panel and their details retained, should a vacancy become available on the Consumer Council within the next year.

Consumer Panel and Consumer Representatives

Consumer Representatives on the Consumer panel were invited to renew their availability and some chose not to continue.

There are gaps in skills, demographics and locality across the Consumer Panel network. It will be important to remedy these gaps as the Consumer Council prepares for a strengthened locality focus. A plan is being made to recruit new panel members and maintain a strong group of active consumer representatives to support co-design work.

Health Reforms

The Health Quality and Safety Commission (HQSC) has been contracted to develop a framework for Consumer Engagement and consumer voices as part of the health and disability reform process. HQSC regularly communicate with the Consumer Councils and will be consulting with the MDHB's Consumer Council as this work progresses.

Consumer Engagement QSM

Members of the Consumer Council are part of the Quality Safety Marker working group. The group meets monthly and is currently developing a work plan that will be used to improve on the current measures submitted by MDHB in March 2021.

Training

The Consumer Council members and Consumer Representatives recently attended a joint training day organised by the Quality and Innovation Directorate Team. The HQSC attended and gave a talk on Consumer Engagement.

Training opportunities will continue several times per annum. The training programme will be planned, in partnership with the Council, based on the needs of consumers and the evaluation of past events.

Consumer Council Engagement

The Consumer Council has engaged and been invited to give input on a wide range of topics in the last six months. The following is a brief outline of these.

Chapel Re-development Consultation	The Consumer Council hosted a meeting on the 1 February 2021 to present the proposal for redevelopment of the Palmerston North Chapel. Members of the community were invited to attend and provide feedback on the proposal. The Consumer Council will continue to follow the progress of the Chapel redevelopment.
Rheumatology Home Visiting Initiative	The Consumer Council was given the opportunity to provide feedback on the new home visiting initiative been introduced by Rheumatology services.
Mental Health and Addictions Integrated Adult Model of Care	The Consumer Council received an overview of the Mental Health and Addictions Ir Adult Model of Care Consultation. Members were

Consultation	impressed with the document and congratulated the team on it. Consumer Council members will receive quarterly updates as the new model is rolled out.
Refugee, Internally displaced person, Migrant and Asylum seeker Programme (RIMA)	MidCentral is a resettlement centre for former refugees. Barriers to health care are been addressed through the THINK Hauora RIMA wellbeing plan. Members welcomed this work and will retain a monitoring brief.
Enabling Good Lives and Mana Whaikaha	The Chair of Mana Whaikaha met with the Consumer Council. He described the difficulties deaf people experience in the health setting accessing deaf interpreting services. Many disabled people report poor health service experiences. The disability communities are keen to see the appointment of a hospital navigator for people with complex health needs.
The Accessibility Charter	The Consumer Council advocated through the Executive Director of Allied Health for the DHB to become a signatory to the Accessibility Charter. The Charter led by the Ministry of Social Development (MSD) requires a commitment by core public sector agencies, Crown entities, District Health Boards and local authorities to work towards an accessible environment for both consumers and employees. MDHB is progressing this work as part of the Disability Strategy.
Mental Health Consumer Network	The Consumer Council met with Te Uru Rauhī Project Lead and the Consumer Advisor, Alcohol and Drug unit, and the Family Whanau Advisor to strengthen relationships with paid DHB consumer facing roles.
Consumer and Clinical Council joint initiatives	The Chairs of both Councils continue to attend both meetings. The two Councils met to participate in a joint workshop to discuss Maori health inequities and the barriers created by racism to accessing and achieving good health outcomes. The Consumer Council focus on Māori health inequities will continue. Further work is being progressed with the support of the General Manager Māori and the General Manager Quality and Innovation.

Consumer Council Work Plan 2021-2022

The 2021/2022 draft work plan is currently being developed. The foci are likely to include:

- Consumer Engagement Quality and Safety Marker
- Health and Disability Reform and implications for consumers and Consumer Councils
- A focus on localities – building connections and understanding the health needs expressed by consumers
- Māori Health and Inequity
- Accessibility Charter – progress towards adoption
- Consumer feedback and themes (compliments and complaints)
- Mental health – implementing the revised model of care
- Facility developments – the new mental health and acute services facilities.

Gail Munro
Consumer Council
July 2021

BOARD REPORT

For:

	Approval
	Endorsement
X	Noting

Key questions the Board should consider in reviewing this paper:

- Has MDHB achieved its commitment to the Safer Staffing Accord by June 2021?
- What are the forthcoming plans for Care Capacity Demand Management (CCDM) roll out?
- How will acuity be monitored in clinical areas not covered by CCDM?

To	Board
Author	Celina Eves, Executive Director Nursing and Midwifery
Endorsed by	Kathryn Cook, Chief Executive
Date	27 July 2021
Subject	**Care Capacity Demand Management**

RECOMMENDATION

It is recommended that the Board:

- **note** the progress of the Care Capacity Demand Management (CCDM) and the Safer Staffing Accord.

Strategic Alignment

This report is aligned to MidCentral District Health Board's (MDHB's) strategy and key enabler 'Strategy'.

CCDM is a nationally-led programme and aligns with MDHB's Organisational Development Plan, specifically a sustainable workforce that is reflective of the communities we serve.

1. PURPOSE

To provide the Board with information on the progress of the CCDM programme within MDHB.

2. SUMMARY

The CCDM programme is in place to address safe staffing issues in New Zealand. The programme was outlined as a priority in the Minister of Health's Letter of Expectations for 2019/20, which sets out the Government's expectations for DHBs. Full implementation of the five CCDM standards was required by 30 June 2021.

MDHB has made significant progress with the implementation of these standards to achieve the required June 2021 implementation date.

- The CCDM Council for MDHB continues to oversee the programme and has representation reflective of the Integrated Services Model.
- Reporting on patient acuity data occurs at a ward level right through to the CCDM Council. The system used is TrendCare.
- Work on the development of the Core Data Set (CDS) to measure CCDM has progressed well. The Qlik system is in place and licences available for the required staff. Reporting from the system for CCDM has been established, with monthly monitoring at ward and council levels.
- Since the last Board report, seven further wards have completed a Full Time Equivalent (FTE) calculation, showing an increase in required FTE.

3. BACKGROUND

The CCDM programme is a set of tools and processes that help DHBs better match the capacity to care with patient demand. The programme is a whole of hospital approach for managing capacity to care on a permanent basis. The goal is quality patient care, quality work environments and best use of health resources.

The CCDM programme is built on a foundation of governance, patient acuity and partnership. The strong union partnership involves New Zealand Nurses Organisation, Public Service Association and Midwifery Employee Representation and Advisory Services. All three union partners have CCDM implementation agreed within their most recent multi-employer collective agreement. Allied Health is now nationally engaged in the programme.

4. MDHB'S CURRENT STATE AND NEXT STEPS

Supported by the Safe Staffing Healthy Workplaces (SSHW) Unit, the CCDM programme at MDHB is building on established CCDM processes within the hospital to further align with the programme standards. National quarterly milestone reporting shows MDHB is currently at 89 percent implementation. This is an increase from early 2021 when the DHB was at 78 percent implementation.

MDHB has completed the Full Implementation Assessment outlining how the requirements of the programme have been achieved. This assessment has been submitted to the SSHW governance group for consideration.

Current progress against each of these standards is outlined below.

4.1 Standard One: Governance

The CCDM governance councils (organisation and ward/unit) ensure that CCDM is planned, coordinated and appropriate for staff and patients.

MDHB's CCDM Council is well established and aligns with the MDHB Integrated Services Model and The Quality Agenda, in particular the Shared Governance Model. The 2021/22 annual plan has been confirmed, focusing on strengthening MDHB's CCDM processes (Appendix One and Two).

The process for ward level governance, in the form of Local Data Councils (LDC) is established using the Qlik system. Twenty of the required 23 metrics are in place and work continues on the remaining three.

Next steps:

- Finalise development of the remaining three Core Data Set (CDS) metrics
- Continue to support ward level reporting on LDC data.

4.2 Standard Two: Validated Patient Acuity Tool (TrendCare)

The validated patient acuity tool underpins CCDM for service delivery.

It is important that patient acuity data is accurate to mitigate the risk that poor quality data has on the ability to undertake FTE calculations and the implementation of the programme. Multiple processes have been put in place to support this, with monthly reporting on patient acuity data occurring at a ward level through to the CCDM Council.

Focused work has recommenced in the Maternity and Birthing Suite due to a significant and ongoing trend of poor-quality data. The area is engaged in the process and increases in data quality are expected by the end of Quarter One. The implementation of TrendCare into the Emergency Department (ED) has commenced with preparations underway for education and training of staff using the system. The go live date for this has yet to be finalized, however it is aimed for early in Quarter Two.

Next steps:

- Ongoing monitoring of data accuracy for the Maternity and Birthing Suite
- Full implementation of TrendCare into ED.

4.3 Standard Three: Core Data Set

The organisation uses a balanced set of CDS measures to evaluate the effectiveness of CCDM over time and to make improvements.

Data visualisation within the DHB has previously been a limiting factor with the progression of this standard. With Qlik in place work initially moved forward with the development of a CCDM dashboard in line with the national CDS published in 2017.

Twenty out of the 23 metrics have been generated in the dashboard since May 2021, and monthly reporting has been implemented with an associated guideline. The CDS working group is overseeing the remaining three metrics.

Next steps:

- Develop the remaining three metrics for CDS and LDC reporting
- Establish reporting processes for CDS through to the Executive Leader.

4.4 Standard Four: Staffing Methodology (FTE Calculation)

A systematic process is used to establish and budget for staffing FTE to ensure the provision of timely, appropriate and safe services.

The results of the FTE calculations will ensure MDHB has the appropriate FTE to meet patient demand. This is an annual calculation and aligns with the annual budget setting processes.

MDHB has completed a further seven FTE calculations (Appendix Three) – Ward, 24, Ward 26, Ward 27, Ward 29, Medical Assessment and Planning Unit, Neonatal Unit and Ward 28/Coronary Care Unit. All areas showed a required increase in FTE to meet the clinical demand. Two other areas are close to completion and two have commenced the calculation process.

Next steps:

- Complete the FTE calculation process for the five areas currently in progress
- Continue the annual FTE calculation process for all areas.

4.5 Standard Five: Variance Response Management (VRM)

The DHB uses a VRM system to provide the right staff numbers, mix and skills at all times for effective patient care delivery.

A VRM system is in place. To improve escalation responses, new standard operating procedures, escalation pathways and associated guiding documents have been implemented with a review of existing processes now underway. Clinical variance hours are monitored and reviewed daily, weekly and monthly at various levels of the organisation.

Next steps:

- Completion of the reallocation of staff guideline review that manages movement of staff between clinical areas to address day-to-day demand.
- Review of the VRM indicators currently used by clinical areas to show any variance between patient demand and capacity to care.

Appendix One: CCDM Risk Register

MidCentral DHB CCDM FY 19-20 Work plan - Issues register					
Risk Number	**Date Identified**	**Risk**	**Impact**	**Mitigation**	**Status**
7	3/03/2020	TrendCare indicators are standardised and do not allow for capturing or considering Māori models of health or cultural safety in the New Zealand context.		Concerns voiced at a national level. TrendCare vendor made aware of the issue from an NZ context. Currently reviewing what is being done at other DHBs and discussions with Paiaka Whaiora Hauora Māori.	Ongoing
10	4/6/2020	Risk of not achieving milestones related to the unknown future impact of COVID-19.		Continue monthly monitoring of milestones and COVID-19 related impact.	Ongoing
12	1/10/2020	Risk of not achieving safe staffing and CCDM implementation for Healthy Ageing and Rehab, STAR 1 and STAR 2.		Plan for TrendCare data improvement underway.	Ongoing
13	25/05/2021	Risk of delays to CCDM timelines due to decreased availability of DHB and NZNO staff related to proposed industrial action		Increased use of Zoom to continue with meetings where able.	Ongoing
14	8/07/2021	Risk of unknown impact of the establishment of Health NZ			Ongoing
Minor	Moderate	Severe			

Appendix Two: MDHB CCDM Annual Plan 2020/21

Standard	No.	Main steps	Jul	Au	Se	Oc	No	De	Jar	Fe	Ma	Ap	Ma	Jur
1. Governance	1	Review CCDM Council Terms of Reference									P	P		
1. Governance	2	Complete standards assessment								P	P			
1. Governance	3	Complete quarterly milestone reporting	C			P			P			P		
1. Governance	4	Educate and Train CN/M with the usage of the QLIK hub for Local Data Council data to strengthen the current process			P	P	P	P	P	P				
1. Governance	5	Undertake Full Implementation assessment and review process	IP	P	P	P	P	P						
1. Governance	6	Undertake a partnership assessment									P	P		
2. Validate patient acuity tool	7	Review DHB Business rules to align with recent changes and new ways of working											P	P
2. Validate patient acuity tool	8	Review patient type benchmarks in CCU and support required changes to practice										P	P	P
2. Validate patient acuity tool	9	Plan, implement, support change and monitor the use of TrendCare within the emergency department including post implementation IRR testing	IP	P	P	P	P	P	P	P	P			
2. Validate patient acuity tool	10	Undertake TrendCare system annual maintenance	IP	P										
2. Validate patient acuity tool	11	Submit planning and undertake Annual IRR testing								P	P	P	P	
3. Core data set	12	Develop outstanding CDS metrics for reporting												
3. Core data set	13	Finalise Core Data Set reporting process through to ELT	IP	P	P									
4. FTE calculation	14	FTE working group agrees phase 1 'ready to go' wards for FTE calculations		P	P									
4. FTE calculation	15	Collect, collate and agree data inputs for agreed wards				P	P	P	P	P				
4. FTE calculation	16	Enter data into software for agreed wards						P	P	P	P	P		
4. FTE calculation	17	Complete roster testing for agreed wards							P	P	P	P	P	
4. FTE calculation	18	Draft report & agree recommendations for agreed wards							P	P	P	P	P	
4. FTE calculation	19	Implement FTE & roster for agreed wards												P
4. FTE calculation	20	Review phase 2 'not quite ready' ward, develop mitigations to FTE barriers and plan an appropriate timeline for FTE calculation			P	P	P							
4. FTE calculation	21	Undertake FTE calculations on phase two wards where appropriate to progress										P	P	P
5. Variance response management	22	Review current VRM indicator scoring	IP	P	P									
5. Variance response management	23	Implement updated VRM indicator scoring				P	P	P						
5. Variance response management	24	Plan new areas suitable for phase 1 VRM implementation			P	P	P							
5. Variance response management	25	Provide VRM education to new usage areas					P	P	P	P	P			
5. Variance response management	26	Monitor, review and report on usage of the VRM by new areas								P	P	P		
5. Variance response management	27	Centralise visability of inpatient rosters to the IOC to assist daily operations and forecasting												
5. Variance response management	28	Increase visability of Allied health with VRM reporting through other therapies and sciences	IP	P	P	P	P	P	P	P				
5. Variance response management	29	Increase visability of Allied health with visualisation of capacity on the HaaG screens	IP	P	P	P	P	P	P	P				

P	IP	C	<30	30-60	>60
Planned	In progress	Completed	Less than 30 days over	30-60 days over	greater than 60 days over

Appendix Three: FTE Calculations to date

- Ten areas completed; some areas have had a second annual calculation completed as part of establishing BAU practice. Four currently undertaking FTE calculations.

Ward Name	Recommended FTE	Variance to budgeted FTE	Increase/ decrease/ no change	Date for implementation
Ward 24	42.88	4.78	Increase	May 2021
Ward 26	50.12	10.48	Increase	May 2021
Ward 27	25.64	5.44	Increase	May 2021
Ward 28/CCU	42.66	9.11	Increase	July 2021
Ward 29	44.71	6.47	Increase	May 2021
Medical Assessment & Planning Unit	30.60	5.32	Increase	May 2021
NNU	29.21	3.58	Increase	May 2021
STAR 2	34.82	0.56	Increase*	July 2020
Ward 23	28.32	4.81	Increase	August 2020
Children's Ward	29.67	3.13	Increase	September 2020
Maternity (in progress)				
Birthing Suite (in progress)				
Ward 21 (in progress)				
Star 4 (in progress)				

*Due to the proposed change in service delivery to STAR 1 and STAR 2 the findings of this calculation will not be implemented

BOARD REPORT

For:

X	Approval
	Endorsement
	Noting

Key questions the Board should consider in reviewing this paper:

- Do the proposed meeting dates enable the Board to meet its governance responsibilities?

To	Board
Author	Margaret Bell, Board Secretary
Endorsed by	Kathryn Cook, Chief Executive
Date	2 August 2021
Subject	**Meeting Dates – 2022**

RECOMMENDATION

It is recommended that the Board:

- **approve** the meeting dates for the Board, the Health and Disability Advisory Committee, and the Finance, Risk and Audit Committee for 2022.

Strategic Alignment

This report is aligned to the DHB's strategy and key enabler 'Stewardship'. It discusses an aspect of effective governance.

1. PURPOSE

To seek approval of dates for the Board, the Health and Disability Advisory Committee (HDAC), and the Finance, Risk and Audit Committee (FRAC) meetings in 2022.

2. BACKGROUND

The Board and Committee meeting schedule is set annually and prepared on a calendar year basis.

In April this year, the Government announced substantial changes to New Zealand's health system, in response to the recommendations of the Health and Disability System Review. A new body, Health New Zealand, will take over the planning and commissioning of services and the functions of the existing 20 District Health Boards from 1 July 2022. Therefore, the proposed dates cover the period from 1 January to 30 June 2022.

To enable the Board to receive the consolidated financial results in a timely manner after the Finance, Risk and Audit Committee (FRAC) meetings, it is proposed that the Board meets two weeks after each FRAC meeting. This will enable the reports to be endorsed by FRAC and then be incorporated into the papers for the following Board meeting. In accordance with the Board's request in 2020, the number of meetings of the Health and Disability Advisory Committee have been reduced.

3. PROPOSED MEETING DATES FOR 2022

The following dates are proposed for 2022, with all meetings held on Tuesdays. After dates have been approved by the Board, calendar meeting invitations will be issued.

Board 9am start	FRAC 9am start	HDAC 9am start	Rem Cttee 1pm start
15 February 2022	**1 February 2022**		
29 March 2022	**15 March 2022**	**1 March 2022**	**15 March 2022**
	26 April 2022		
10 May 2022		**24 May 2022**	
28 June 2022	**14 June 2022**		

Information papers

17 August 2021

Printed from Stellar by
Margaret Bell <margaret.bell@midcentraldhb.govt.nz>

BOARD REPORT

For:

	Approval
	Endorsement
X	Noting

Key questions the Board should consider in reviewing this paper:

- Does the work programme include the topics needed to confidently govern?

To	Board
Author	Margaret Bell, Board Secretary
Endorsed by	Rory Matthews, Interim Director of the Office of the Chief Executive
Date	2 August 2021
Subject	**Board's Work Programme**

RECOMMENDATION

It is recommended that the Board:

- **note** the Board's annual work programme.

Strategic Alignment

This report is aligned to the DHB's strategy and key enabler 'Stewardship'. It discusses an aspect of effective governance.

1. PURPOSE

To provide an update on the Board's work programme.

2. 2021 BOARD WORK PROGRAMME

The Board's work programme for 2021 was approved in December 2020. At its meeting in May 2021, the Board agreed that this work programme would be 'rolled over' for the period from 1 January to 30 June 2022.

Reporting is occurring in line with the work programme.

MDHB BOARD Work Programme

	Frequency	Feb	Apr	May	Jul	Aug	Sep	Nov	Dec	Responsible
Key Updates										
CEO's Report to provide an update on key progress of the DHB	Each meeting	X	X	X	X	X	X	X	X	CEO
FRAC Minutes and Verbal Update from the FRAC Chair to update the Board on key committee discussions	Each meeting Minutes	X Dec/Feb	X March	X May	X June	X July	X Sept	X Oct	X Nov	FRAC Chair
HDAC Minutes and Verbal Update from the HDAC Chair to update the Board on key committee discussions	Each meeting Minutes	X None	X Feb	X April	X None	X July	X None	X Sept	X Nov	HDAC Chair
Strategy and Planning										
DHB Strategy to review/refresh the DHB's strategy to ensure it remains relevant, and to consider how it has been advanced, and priorities for the future	Triennial (due Dec 2023)									GM SPP
Annual Plan and Budget to determine the draft and final budget and priorities for the next three years, including capex plan	One off then six-weekly from Dec-Jun	X	X	X	X				X	GM SPP GM F&CS
Workforce Strategy to establish/review the strategy based on the national framework (support the execution of the DHB's Strategy)	Triennial (due TBC)									GM P&C
Organisational Development Plan review/refresh (relevant and supports the execution of the DHB's Strategy)	Triennial (due Nov 2022)									GM P&C
Contract Renewal and Planning Outcomes Framework review planning outcomes achieved and general approach to contracting for year ahead	Annual			X						GM SPP
Quality Improvement										
Quality Account to determine the Quality Account for the financial year (via HDSAC)	Annual								X	GM Q&I
Quality and Safety Walk-rounds to provide the Board a summary of the walk-rounds from over the last 12 months	Annual			X						GM Q&I
Workforce										
Health and Safety to monitor the implementation of the H&S Strategy, mitigations required, priorities for the future, including investment	Quarterly	X		X		X		X		GM P&C
Health and Safety Workshop	Annual		X							GM P&C
Workforce and Organisational Development to monitor the health of the DHB's workforce, including trends and performance against workforce dashboard and adequacy of any mitigations to monitor the implementation of the OD strategy, what's changed, priorities for the future (three to five years), investment and resources required, and the adequacy of any mitigations	Six-monthly			X				X		GM P&C
Preventing Occupational Violence Strategy to monitor the implementation, priorities, investment and adequacy of any mitigations	Annual	X								GM P&C

MDHB BOARD Work Programme	Frequency	Feb	Apr	May	Jul	Aug	Sep	Nov	Dec	Responsible
Wellbeing Plan (aka Psychosocial Wellbeing Strategy) to monitor the implementation of the DHB's health and wellbeing plans	Annual	X								GM P&C
Care Capacity Demand Management to monitor the implementation of the National Accord and local CCDM decisions	Six-monthly	X				X				ED N&M
Remuneration Policy to consider the Remuneration Policy as recommended by the Remuneration Committee	Triennial (Due Nov 2022)									GM P&C
IEA Remuneration Strategy to consider the Remuneration Strategy (IEAs) as recommended by the Remuneration Committee	Triennial (due Mar 2023)									GM P&C
IEA Remuneration Parameters to consider the remuneration parameters for annual changes to staff on IEA agreements following Rem Committee	Annual								X	GM P&C
Performance										
Financial Performance to monitor the DHB's financial performance against budget, including trends, forecasts, the impact of business improvement initiatives and opportunities and challenges, and confirm the adequacy of any mitigations	Six-weekly	X	X	X	X	X	X	X	X	GM F&CS
DHB Performance Metrics (aka Board KPI Dashboard) to monitor high level KPIs across the DHB	Six-weekly	X	X	X	X	X	X	X	X	GM SPP
Digital Strategy – implementation of roadmap to monitor implementation, challenges and opportunities, priorities and initiatives/investments for future, and confirm the appropriateness of any mitigations	Six-weekly	X	X	X	X	X	X	X	X	CDO
Sustainability Plan to monitor the implementation of the performance improvement programme	Six-weekly	X	X	X	X	X	X	X	X	GM Q&I
Non-Financial Performance Measures to monitor the overall performance of the DHB	Quarterly		X		X		X		X	GM SPP
CEO's Performance Review	Annual					X				Chair
Audit										
Annual Accounts to determine the annual accounts for the financial year and to determine Enable NZ Limited annual reporting requirements	Annual						X			GM F&CS
Year End Audit Process (Government) to determine year-end financial result for inclusion in Government accounts	Annual				X					GM F&CS
Enable NZ Limited Annual Reporting Arrangements to determine annual reporting requirements of this paper company	Annual			X						GM F&CS
Iwi Partnerships										
Memorandum of Understanding to review the Memorandum of Understanding	Triennial (due Sept 2021)						X			GM M
DHB Board and Manawhenua Hauora Joint Work Programme to monitor progress against shared work programme, including opportunities and challenges	Six-monthly		X				X			GM M

MDHB BOARD Work Programme

	Frequency	Feb	Apr	May	Jul	Aug	Sep	Nov	Dec	Responsible
Board-to-Board Hui	Quarterly	X		X		X		X		GM M
to monitor progress against shared work programme, including opportunities and challenges										
Manawhenua Hauora Update	Six-weekly	X	X	X	X	X	X	X	X	GM M
to update the Board on the Manawhenua Hauora discussions										
Partnership										
Clinical Council	Six-monthly	X				X				GM Q&I
to consider the work, findings and recommendations from the Council, provide endorsement or support as required										
Consumer Council	Six-monthly	X				X				GM Q&I
to consider the work, findings and recommendations from the Council, provide endorsement or support as required										
Professional Work Groups	Four-monthly		ED N&M		CMO				ED AH	Prof Leads
Profession										
Governance of shareholding companies										
to monitor the annual results and plans of shareholding companies and determine actions in respect of AGM recommendations										
Regional Service Plan	Annual				X					GM SPP
to approve the draft and final regional budget and priorities										
Allied Laundry Services Limited	Annual							X		GM F&CS
Technical Advisory Services AGM (DHB Shared Services)	Annual							X		GM SPP
NZ Health Partnerships Limited	Quarterly		X		X		X		X	GM F&CS
Board Governance Arrangements										
Board Governance arrangements and Committee Terms of Reference	Triennial or as required				X					Chair
Annual Reporting Framework (work programme)	Annual			X				X		CEO
Annual Board Evaluation	Annual							X		GM P&C
Annual meeting schedule	Triennial						X			CEO
Committee membership	Triennial							X		Chair
External committee membership and appointments	Triennial							X		Chair
Te Tiriti o Waitangi	Triennial						X			GM M
Review of Board policies	As required									CEO
Review of policies related to the Board or those requiring Board approval										

Key:

CEO	Chief Executive Officer
ED N&M	Executive Director, Nursing and Midwifery
GM F&CS	General Manager, Finance and Corporate
GM M	General Manager, Māori Health
CMO	Chief Medical Officer
FRAC Chair	Chair of the Finance, Risk and Audit Committee
Chair	Board Chair of the MidCentral District Health Board
GM P&C	General Manager, People and Culture
GM Q&I	General Manager, Quality and innovation
GM SPP	General Manager, Strategy, Planning and Performance
ED AH	Executive Director, Allied Health
Prof Leads	CMO, ED N&M, ED AH
HDAC Chair	Chair of the Health and Disability Audit Committee
CDO	Chief Digital Officer

Workshop Schedule

As at 17 June 2021

Date	Time	Topic
16 February 2021	Following HDAC meeting	Stellar Board Management Platform
23 February 2021	Following Board meeting	Midwifery Workforce Engagement
13 April 2021	Following Board meeting	Board Self-evaluation (with Broad Horizons)
20 April 2021	From 9am to noon	Annual Planning and Budget
27 April 2021	Following HDAC meeting	Consumer Story
25 May 2021	Following Board meeting	Manawhenua Hauora Board to Board hui
15 June 2021	Following FRAC meeting	Conjoint meeting of Board and FRAC – 2021/22 Annual Plan and Budget
6 July 2021	Following Board meeting	Medical Workforce
13 July 2021	Following HDAC meeting	Consumer Story
27 July 2021	Following FRAC meeting	Medical Workforce and Combined Medical Staff Association
17 August 2021	Following Board meeting	Annual Risk Workshop
9 November 2021	Following Board meeting	Manawhenua Hauora Board to Board hui
23 November 2021	Following HDAC meeting	Consumer Story
TBA in 2022	Following Board meeting	Health and Safety – with Buddle Findlay

Glossary of terms

17 August 2021

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Glossary of Terms

AC	**Assessment Centre**
ACC	**Accident Compensation Corporation** The New Zealand Crown entity responsible for administering the country's no fault accidental injury compensation scheme.
ACCPP	**Accident Compensation Corporation Partnership Plan**
ACE	**Advanced Choice of Employment**
ACT	**Acute Crisis Team**
ADL	**Activities of Daily Living**
ADON	**Associate Director of Nursing**
AESS	**Te Uru Arotau Acute and Elective Specialist Services**
ALOS	**Average Length of Stay**
Anti- VEGF	**Anti-Vascular Endothelial Growth Factor**
AoG	**All of Government**
AP	**Annual Plan** The organisation's plan for the year.
APEX	**Association of Professional and Executive Employees**
API	**Application Programming Interfaces**
ARC	**Aged Residential Care**
ASH	**Ambulatory Sensitive Hospitalisations**
AS/NZS ISO 31000	**2018 Risk Management Principles and Guidelines**
AWS	**Amazon Web Services**
B Block	**Wards, Laboratory, Admin and Outpatients**
BAG	**Bipartite Action Group**
BAPSF	**Bereavement leave, Alternative days, Public holidays, Sick leave, Family Violence leave**

BAU	**Business as Usual**
BN	**Bachelor of Nursing**
BSCC	**Breast Screen Coast to Coast**
BYOD	**Bring Your Own Device**
CAG	**Cluster Alliance Group** A group or 10-12 members from across the health and wider sector supporting the Cluster Leadership Team to identify population health needs, planning, commissioning and evaluating services and developing models of care. Members include consumer and Māori representatives.
CAPEX	**Capital Expenditure**
CBAC(s)	**Community Based Assesment Centre(s)**
CCDHB	**Capital and Coast District Health Board**
CCDM	**Care Capacity Demand Management** A programme that helps the organisation better match the capacity to care with patient demand.
CCTV	**Closed Circuit Television**
CCU	**Critical Care Unit**
CDO	**Chief Digital Officer**
CDS	**Core Data Set**
CE	**Clinical Executive** (of a service)
CE Act	**Crown Entities Act**
CEO	**Chief Executive Officer**
CFIS	**Crown Financial Information System**
CHF	**Congestive Heart Failure**
CIMS	**Coordinated Incident Management System**
CIO	**Chief Information Officer**
CLAB	**Central Line Associated Bacteraemia**

CME	**Continuing Medical Education**
CMO	**Chief Medical Officer**
CN	**Charge Nurse(s)**
CNM	**Clinical Nurse Manager**
CNS	**Clinical Nurse Specialist**
COI	**Committee of Inquiry**
ComM	**Communications Manager**
COPD	**Chronic Obstructive Pulmonary Disease** A common lung disease which makes breathing difficult. There are two main forms, Chronic bronchitis - a long term cough with mucus. Emphysema - which involves damage to the lungs over time.
COVID-19	**Novel Coronavirus**
CPAC	**Prioritisation scoring system code table**
CPB	**Combined Pharmaceutical Budget**
CPHO	**Central Primary Health Organisation**
CPI	**Consumer Price Index**
CPOE	**Computer Physician Order Entry**
CRM	**Cyber Risk Monitoring**
CSB	**Clinical Services Block**
CT	**Computed Tomography** A CT scan combines a series of X-ray images taken from different angles around your body and uses computer processing to create cross-sectional images of the bones, blood vessels and soft tissues inside your body.
CTAS	**Central Technical Advisory Services** (also TAS)
CTCA	**Computed Tomography Coronary Angiography** A CT scan that looks at the arteries that supply blood to the heart. Can be used to diagnose the cause of chest pain or other symptoms.
CVAD	**Central Venous Access Device**

CWDs	**Case Weighted Discharges** Case weights measure the relative complexity of the treatment given to each patient. For example, a cataract operation will receive a case weight of approximately 0.5, while a hip replacement will receive 4 case weights. This difference reflects the resources needed for each operation, in terms of theatre time, number of days in hospital, etc.
DCFO	**Deputy Chief Financial Officer**
DDIGG	**Digital and Data Informatics Governance Group**
DHB	**District Health Board**
DIVA	**Difficult Intravenous Access**
DNA	**Did Not Attend**
DNW	**Did Not Wait**
DoN	**Director of Nursing**
DS	**Digital Services**
DSA	**Detailed Seismic Assessment**
DSA	**Digital Subtraction Angiography**
DWP	**Digital Workplace Programme**
DX	**Data Exchange** A data exchange software mechanism developed with the Social Investment Agency (SIA) to support encrypted data sharing between public services.
EAP	**Employee Assistance Programme**
EBITA	**Earnings Before Interest, Taxes and Amortisation**
ECM	**Enterprise Content Management**
ED	**Emergency Department**
EDAH	**Executive Director Allied Health**
EDG-VPSR	**Electrocadiograph – Visual Positioning System Rhythm**
EDN&M	**Executive Director, Nursing & Midwifery**

EDOA	**Emergency Department Observation Area**
EDON	**Executive Director of Nursing**
EECA	**Energy and Efficiency Conservation Authority**
ELT	**Executive Leadership Team**
EMERGO	**Emergo Train System**
EMR	**Electronic Medical Record**
EN	**Enrolled Nurse**
ENT	**Ear Nose and Throat**
ENZ	**Enable New Zealand**
EOC	**Emergency Operations Centre**
EP	**Efficiency Priority**
EPA	**Electronic Prescribing and Administration**
EPMO	**Enterprise Project Management Office**
ERCP	**Endoscopic Retrograde Cholangio Pancreatography**
ERM	**Enterprise Risk Management**
ESPI	**Elective Services Patient Flow Indicator** Performance measures that provide information on how well the District Health Board is managing key steps in the electives patient journey.
EV	**Electric Vehicle**
EWS	**Early Warning System**
EY	**Ernst & Young**
FACT	**Flexible Assertive Community Assessment Team**
FHC	**Feilding Health Care**
FHIR	**Fast Healthcare Interoperability Resources**
FIT	**Faecal Immunochemical Test**

FM	**Facilities Management**
FM Services	**Facilities maintenance and hotel services required by the DHBs**
FPIM	**Finance and Procurement Information Management System**
FPM	**Financial Planning Manager**
FRAC	**Finance, Risk and Audit Committee**
FSA	**First Specialist Appointment**
FSL	**Fire Service Levies**
FTE	**Full Time Equivalent** The hours worked by one employee on a full-time basis.
FU	**Follow Up**
Gap	**Analysis used to examine current performance with desired, expected performance**
GETS	**Government Electronic Tenders Service**
GHG	**Greenhouse Gases**
GM	**General Manager**
GMFCS	**General Manager, Finance and Corporate Services**
GMM	**General Manager, Māori Health**
GMPC	**General Manager, People and Culture**
GMQI	**General Manager, Quality and Innovation**
GMSPP	**General Manager, Strategy, Planning and Performance**
GP	**General Practitioner**
GST	**Goods and Services Tax**
H&S	**Health and Safety**
HaaG	**Hospital at a Glance**
HAI	**Healthcare Associated Infection**
HAR	**Te Uru Whakamauora, Healthy Ageing and Rehabilitation**

HBDHB	**Hawke's Bay District Health Board**
HCA(s)	**Health Care Assistant(s)**
HCSS	**Home and Community Support Services**
HDAC	**Health and Disability Advisory Committee**
HDU	**High Dependency Unit**
HEAT	**Health Equity Assessment Tool**
HEEADSSS	**Home, education/employment, eating, activities, drugs, sexuality, suicide and depression, safety (wellness assessment)**
HIP	**Health Infrastructure Programme**
HISO	**Heath Information Security Framework**
HQSC	**Health, Quality and Safety Commission**
HR	**Human Resources**
HRC	**Health Research Council**
HRIS	**Human Resources Information System**
HROD	**Human Resources and Organisational Development**
HSWA	**Health and Safety at Work Act**
Hui	**Formal meeting**
HV	**High Voltage**
HVAC	**Heating, Ventilation and Air Conditioning**
HVDHB	**Hutt Valley District Health Board**
HWIP	**Health Workforce Information Programme**
HWNZ	**Health Workforce New Zealand**
IA	**Internal Audit**
IAAS	**Infrastructure as a Service**
IAP	**Incident Action Plans**

ICNet	**Infection Control Surveillance**
ICPs	**Incident Control Points**
ICPSA	**Integrated Community Pharmacy Services Agreement**
ICT	**Information and Communications Technology**
ICU	**Intensive Care Unit**
IDF	**Inter-district Flow** The default way that funding follows a patient around the health system irrespective of where the are treated.
IEA	**Individual Employment Agreement**
IFHC	**Integrated Family Health Centre** General practice teams with the patient at the centre, providing quality health care when, where and how patients need it.
IFM / IFM20	**Integrated Facilities Management**
IL	**Importance Level** Seismic assessment rating
IMAC	**Immunisation Advisory Centre**
IMT	**Incident Management Team**
Insourced	**Delivered directly by the DHBs via its staff**
IOC	**Integrated Operations Centre**
IOL	**Intraocular Lens**
IOT	**Internet of Things**
IPSAS	**International Public Sector Accounting Standards**
IS	**Information Systems**
ISM	**Integrated Service Model**
ISP	**Internet Service Provider**
IT	**Information Technology/Digital Services**

ITSM	**Integrated Service Module**
IV	**Intravenous**
IVP	**Improving Value Programme**
JDE	**JD Edwards** Name of software package
Ka Ao Ka Awatea	**Māori Health Strategy for the MDHB District**
KPI(s)	**Key Performance Indicator(s)** A measurable value that demonstrates how effectively an objective is being achieved.
LAN	**Local Area Network**
LDC	**Local Data Council**
LEO	**Leading an Empowered Organisation**
LMC	**Lead Maternity Carer**
LOS	**Length of Stay**
LSP	**Leadership Success Profile**
LTC	**Long Term Condition(s)**
LV	**Low Voltage**
MALT	**Māori Alliance Leadership Team**
MAPU	**Medical Assessment and Planning Unit**
MBIE	**Ministry of Business, Innovation and Employment**
MCH	**MidCentral Health**
MCIS	**Maternity Clinical Information Service**
MDBI	**Material Damage and Business Interruption**
MDHB	**MidCentral District Health Board**
MDM	**Master Data Management**
MDT	**Multi-disciplinary Team**

MECAs	**Multi Employer Collective Agreements**
MEED	**Midwifery External Education and Development Committee**
MERAS	**Midwifery Employee Representation and Advisory Service**
MFA	**Multi-Factor Authentication**
MIT	**Medical Imaging Technologist** A radiographer who works with technology to produce X-rays, CT scans, MRI scans and other medical images.
MIYA	**MIYA Precision Platform**
MoH	**Ministry of Health**
MOU	**Memorandum of Understanding**
MRI	**Magnetic Resonance Imaging** A medical imaging technique used in radiology to form pictures of the anatomy using strong magnetic fields and radio waves.
MRSO	**Medical Radiation Officer**
MRT	**Medical Radiation Therapist(s)**
MSD	**Ministry of Social Development**
MWH	**Manawhenua Hauora**
MYFP	**Midwifery First Year of Practice Programme**
NAMD	**Neovascular Age-Related Macular Degeneration**
NARP	**Non-Acute Rehabilitation Programme**
NBSP	**National Bowel Screening Programme**
NCAMP19	**National Collections Annual Maintenance Programme 2019**
NCEA	**National Certificate of Educational Achievement**
NCNZ	**Nursing Council of New Zealand**
NEAC	**National Ethics Advisory Committee**
NEED	**Nursing External Education and Development Committee**

NESP	**Nurse Entry to Specialty Practice Programme (Mental Health)**
NETP	**Nurse Entry to Practice**
NFSA	**National Food Services Agreement**
NGO	**Non Government Organisation**
NHAWG	**National Holidays Act Working Group**
NNU	**Neo Natal Unit**
NOS	**National Oracle Solution**
NP	**Nurse Practitioner**
NPC	**Nurse Practitioner Candidate**
NPTP	**Nurse Practitioner Training Programme**
NZ	**New Zealand**
NZCOM	**New Zealand College of Midwives**
NZCPHCN	**New Zealand College of Primary Health Care Nurses**
NZCRMP	**New Zealand Code of Radiology Management Practice**
NZD	**New Zealand Dollar**
NZHP	**New Zealand Health Partnerships**
NZHRS	**New Zealand Health Research Strategy**
NZNO	**New Zealand Nurses Organisation**
NZPHD Act	**New Zealand Public Health and Disability Act**
O&G	**Obstetrics and Gynaecology**
OAG	**Office of the Auditor-General**
OD	**Organisational Development**
ODP	**Organisational Development Plan**
OE	**Operations Executive** (of a service)

OHS	**Occupational Health and Safety**
OLT	**Organisational Leadership Team** OLT comprises all General Managers, Chief Medical Officer, Executive Directors - Nursing & Midwifery and Allied Health, General Manager of Enable NZ, all Operations Executives and Clinical Executives.
OPAL	**Older People's Acute Assessment and Liaison Unit**
OPERA	**Older People's Rapid Assessment**
OPF	**Operational Policy Framework**
Outsourced	**Contracted to a third-party provider to deliver**
Pae Ora Paiaka Whaiora	**(Base/Platform of health) Healthy Futures (DHB Māori Directorate)**
PACS	**Picture Archiving Communication System**
PANE	**Proactive, Advocacy, Navigation and Education Team**
PAS	**Patient Administration System**
PBE	**Public Sector Benefit Entity**
PCBU	**Person Conducting a Business or Undertaking**
PCT	**Pharmacy Cancer Treatment**
PDRP	**Professional Development and Recognition Programme**
PDSA	**Plan Do Study Act**
PEDAL	**Post Emergency Department Assessment Liaison**
PET	**Positron Emission Tomography**
PHC	**Primary Health Care**
PHO	**Primary Health Organisation (THINK Hauora)**
PHU	**Public Health Unit**
PICC	**Peripherally Inserted Central Catheter**
PICU	**Paediatric Intensive Care Unit**

PIN	**Provisional Improvement Notice** (section 36.2 Health and Safety at Work Act 2015)
PIP	**Performance Improvement Plan** This plan is designed to support the OLT in the prioritisation and optimisation of system wide efforts to achieve our vision. The plan was presented to the MoH as part of MDHB's 2019/20 strategic discussion.
PNCC	**Palmerston North City Council**
POAC	**Primary Options for Acute Care**
PPE	**Personal Protective Equipment**
Powhiri	**Formal Māori Welcome**
PPA	**Promoting Professional Accountability**
PPC	**Public, Primary and Community**
PP&CH	**Public, Primary and Community Health**
PPPR	**Protection of Personal and Property Rights**
PR&RO	**Principal Risk and Resilience Officer**
PSA	**Public Service Association**
PSe	**PS Enterprise**
PSR	**Protective Security Requirements**
PVC	**Poly Vinyl Chloride**
QEAC	**Quality & Excellence Advisory Committee**
QHP	**Qualified Health Plan**
Qlik	**Qlik Sense Data Visualisation Software (Dashboard Analytics)**
Q&SM	**Quality and Safety Markers**
RACMA	**Royal Australasian College of Medical Administrators**
RDHS	**Regional Digital Health Services**
RFP	**Request for Proposal**

RHIP	**Regional Health Infometrics Programme** Provides a centralised platform to improve access to patient data in the central region.
Risk ID	**Risk Identifer**
RM	**Registered Midwife**
RMO	**Resident Medical Officer**
RN	**Registered Nurse(s)**
RP	**Risk Priority**
RSI	**Relative Stay Index**
RSO	**Research Support Officer**
RSP	**Regional Service Plan**
RTL	**Round Trip Logistics** A technology platform.
Rules	**Government Procurement Rules (4th Edition 2019)**
SaaS	**Software as a Service**
SAC	**Severity Assessment Code**
SAN	**Storage Area Network**
SBA	**Smoking Brief Advice (Smoking Cessation)**
SFIA	**Skills Framework for the Information Age**
SGOC	**Shared Goals of Care**
SIEM	**Security Information Event Monitoring**
SLA	**Service Level Agreement**
SLMs	**System Level Measures**
SME	**Subject Matter Expert(s)**
SMO	**Senior Medical Officer**
SNE	**Services Not Engaged**

SOI	**Statement of Intent**
SOR	**Standard Operating Responses**
SPE	**Statement of Performance Expectations**
SPIRE	**Surgical Procedural Interventional Recovery Expansion** A project to establish additional procedural, interventional and surgical resources within MDHB.
Spotless	**Spotless Services (NZ) Limited**
SRG	**Shareholder's Review Group**
SSC	**State Services Commission** (from 2020 - Te Kawa Mataaho Public Service Commission)
SSHW	**Safe Staffing, Healthy Workplaces**
SSIED	**Shorter Stays in Emergency Department**
SSP	**Statement of Service Performance**
SSU	**Sterile Supply Unit**
SUDI	**Sudden Unexpected Death in Infancy**
SUG	**Space Utilisation Group**
STAR	**Services for Treatment, Assessment and Rehabiliation**
TAS	**Technical Advisory Services** (also CTAS)
TCO	**Total Cost of Ownership**
tC02e	**tons of carbon dioxide equivalent**
TCU	**Transitional Care Unit**
THG	**Tararua Health Group Limited**
TKMPSC	**Te Kawa Maataho Public Service Commission** (formerly State Services Commission)
TLP	**Transformational Leadership Programme**
Trendly	A national database capture tool and dashboard that focuses on the measurement of DHBs to the National Māori Health Measures

TTOR	**Te Tihi o Ruahine Whānau Ora Alliance**
UCOL	**Universal College of Learning**
VBS	**Voluntary Bonding Scheme**
VRM	**Variance Response Management**
WDHB	**Whanganui District Health Board**
WebPAS	**Web Based Patient Administration System**
WebPASaas	**Web Based Patient Administration System as a Service**
WHEI	**Whole Hospital Escalation Indicators**
Y	**Yes**
YD	**Yes and delegable**
YOSS	**Youth One Stop Shop**
YTD	**Year To Date**

Late items - discussion

17 August 2021

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Late items

Discussion on any late items advised at the start of the meeting

Date of next meeting

17 August 2021

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Date of next meeting

Tuesday, 28 September 2021

Exclusion of the public

17 August 2021

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Exclusion of public

Resolution:

That the public be excluded from this meeting in accordance with the Official Information Act 1992, section 9 for the items and reasons outlined in the agenda.